South Carolina
Applicaton for Therapy Services

CLIENT'S INFORMATION

Name: _____ *Gender: ○ Male ○ Female DOB: _____

Medicaid Number: _____ SSN: _____

Address Where Services Were Performed: _____

Services Requested By: _____

CURRENT PLACEMENT

○ Family Home ○ Foster Home ○ Group Home ○ TFC If yes, Level ○ I ○ II ○ III

PARENT/GUARDIAN/FOSTER PARENT

Name: _____

Relationship: _____ Phone: _____

REFERRAL SOURCE

○ Self ○ State Agency ○ Other: _____

Contact Person: _____

Relstionship: _____ County: _____

Phone: _____ Email: _____

BILL TO

○ Select Health ○ WellCare ○ BlueChoice ○ Molina ○ Cenpatico ○ SCDHHS ○ SCDSS

If SCDSS, County: _____

SERVICE(S) NEEDED

○ Diagnostic Assessment Date of last assessment: _____

○ Individual Psychotherapy ○ Group Psychotherapy ○ Family Psychotherapy ○ Psychosocial Rehabilitative Services

○ Family Support ○ B-Mod

Family Preservation Community Services

REASON FOR REFERRAL

AUTHORIZATION

Signature

Date

***Please return this form by email to outpatientreferrals@fpcscorp.com or fax to (803) 782-3426.**

Family Preservation Community Services