



TWICOUNSELING



Toll Free: 866.537.9280

Albany Fax: 229.435.7474 Atlanta Fax: 404.393.6465

Augusta Fax: 706.228.3233 Vidalia Fax: 912.537.9440

Savannah Fax: 912.234.7884

Date of Referral: _____ Date Received: _____ County _____

Case Manager: _____ E-mail Address: _____

Contact Numbers (Office) _____ (Cell) _____

Service(s) Requested: *PLEASE INCLUDE AUTHORIZATION CODES
FOR ALL SERVICES REQUESTED*****

Placement Services: (Please check all that apply)

- Family Team Meeting**
- Psychological Evaluation**
- Relative Home Evaluation**
- Comprehensive Child and Family Assessment (CCFA)**
- Wrap-Around Services: (Please check all that apply)** _____ hours for _____ weeks
 - Code 53 Transportation
 - Code 71 In-Home Case Management
 - Code 24 Crisis Intervention Prevent Disruption
 - Code 47 Crisis Intervention Behavioral Management
 - Code 88 Court Appearance and/ or Testimony
 - Code 12 Other Reimbursable Service
 - Code 95 In-Home Intensive Treatment

Child Protective Services/ Ongoing: (Please check all that apply)

- Psychological Evaluation**
- Code 551 Early Intervention and Preventive Services (Unsubstantiated)**
- Code 571 Homestead (In-Home Intensive Counseling)**
- Code 571 Homestead (In-Home Intensive Counseling)**
- Substance Abuse Assessment Domestic Violence Assessment Anger Management
- Code 573 Parent Aid Services (In-Home Parenting Skills Training)**
- Parenting Assessment Parenting Classes

Consumer Basic Information:

Client Name: _____ Client Case # _____

Date of Birth: _____ Social Security #: _____

Medicaid #: _____ Authorization # _____

Contacts Numbers: _____

Residential Address: _____

(City)

(County)

(State)

(ZipCode-9 Digits)

Family/Relatives In-Home/Involved in Referral:

Last Name	First Name	Gender	Ethnicity	Relationship To Client	DOB	Placement Code

Presenting Circumstances State the Individual's request and circumstances surrounding the request.

TWI COUNSELING IS A FAMILY SUPPORT SERVICE CENTER ASSISTING FAMILIES THROUGHOUT THE STATE OF GEORGIA.



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Name of Individual/Consumer/Patient/Applicant

Date of Birth
IF AVAILABLE

Id # Used by Requesting Org.

ID # used by Releasing

I hereby request and authorize: TWI Counseling

(Name of Person or Agency Requesting the Information)

506 Donovan Street, Vidalia, Georgia

(Address)

To obtain from:

(Name of Person or Agency Holding the Information)

(Address)

The following type(s) of information from my records (and any portion thereof):

For the purpose of: _____

I understand that the federal Privacy Rule ("HIPPA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

Ninety (90) days unless I specify an earlier expiration date here: _____ (Date)

One (1) year.

The period necessary to complete all transactions on accounts related to services provided to me. I understand that unless otherwise limited by state and federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) Title of Relationship to Individual

X

(Signature of Parent or Legally Authorized Representative, when Applicable)

Use this Space if Authorization is Withdrawn

(Date Authorization is revoked)

(Signature of Patient or other Legally Authorized Representative, when applicable)