***Prior to submitting this form to the Division of Behavioral Health, the Client Information screen must be completed in STARS.***

Date form completed: ­­­\_\_\_/\_\_\_/\_\_\_\_\_

**­­­COMPLETED BY AGENCY STAFF**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Client: | | | |
| STARS ID: | | | |
| JCA/CSO/CPS: | | | |
| Referred Program: Choose an item. | | | Admitting Program: Choose an item. |
| \*Add Additional Information if Admitting Program is Different than Referred Program: | | | |
| Group Start Date (if applicable): | | Group Day(s)/Time (if applicable): | |
| Agency Providing Services: Choose an item. | | Counselor Providing Services: | |
| Program Start Date (please submit PSN after services have started): | | | |
| Source of Payment: | | | |
| Medicaid | Medicaid Recipient Number: | | |
| State Contract Funding | | | |
| Private Insurance | | | |
| Other: | | | |
| Was means testing completed? Yes:  No: | | | |
| Does the client meet financial eligibility? Yes:  No:  (No, hardship consideration is needed) | | | |

\*\*If client does not meet financial eligibility, services will be funded with state contract funds\*\*

**COMPLETED BY DBH PROGRAM SPECIALIST**:

|  |
| --- |
| Date Form Received: |
| Date Approved: |
| Time Frame Approved for: to |
| Number of Sessions Approved: |
| Prior Authorization Number: |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Specialist Signature Date