***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