Pathways, Inc.

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**Community Oriented Recovery and Empowerment (CORE) Services**
**Adult Behavioral Health (BH) Home and Community Based Services (HCBS)**
**Referral Form**

**Member information**

Member Name _____ Member DOB _____

Member Phone _____ Member Email (optional) _____

Member Address _____

Member County _____ Member Gender Identity Male ☐ Female ☐

Member Medicaid ID _____ MCO __ _____ Plan ID _____

Member ICD-10 Diagnosis Code(s) : _____

Status: Tier I _____ Tier II _____

Health Home _____ Health Home Care Manager _____

HH Address: _____ Phone _____ Email _____

**Adult BH HCBS requested**

Please select services for which authorization is requested:

**CORE Services**

- ☐ Psychosocial Rehabilitation (PSR)
- ☐ Family Support and Training (FST)
- ☐ Empowerment Services – Peer Support

**HCBS Services**

- ☐ Education
- ☐ Prevocational
- ☐ Intensive Supported Employment (ISE)
- ☐ Ongoing Supported Employment
- ☐ Habilitation

Describe any other barriers or obstacles to the member's goals/objectives, and strategies to address them:

_____

_____

_____

_____

_____

_____ I attest that the member has elected to receive the CORE Services and/or Adult BH HCBS requested above.

Signature of Provider: _____ Date: _____

Name (please print): _____

Title: _____

**Date Received** _____ **LPHA Completed:** _____ **MCO LOS:** _____ **Assigned to:** _____
(for business office use only)

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