|  |  |  |
| --- | --- | --- |
|  | **Washington State Department of CHILDREN, YOUTH & FAMILES**  **PSYCHOLOGICAL SERVICES REFERRAL FORM** This authorization is valid for up to 180 days from the date of this referral | Date of Referral |

|  |  |  |  |
| --- | --- | --- | --- |
| Starting Date |  | Ending Date |  |
| Provider Name | Harborview Foster Care Clinic | FamLink Provider ID | 6393 |
| DCYF Caseworker |  | Phone Number |  |
| DCYF Office |  | FamLink Case ID |  |
| Client’s Name  (For Children also give caregiver’s name) |  | Client’s Phone Number |  |

**Allowed Hours & Rates** are posted at <https://www.dcyf.wa.gov/sites/default/files/pdf/Fee-PsychologicalServices.pdf>

If DCYF is paying for the evaluation or a specific month of counseling, providers cannot accept other funding.

|  |  |  |  |
| --- | --- | --- | --- |
| **SERVICE REQUESTED** | | **Maximum Hours** | **Hours Authorized** |
|  | **Psychological Evaluation**  (Testing with interpretation and report) | 10 hours |  |
|  | **Neuropsychological testing battery & neurobehavioral status exam with interpretation & report –** (Conducted in addition to the work done under the Psychological Evaluation above) | 2 additional hours |  |
|  | **Parenting Evaluation / Parenting Component**  (Conducted in addition to the work done under the Psychological Evaluation above) | Up to 5 additional hours |  |
|  | **Psychotherapy with written report**  **Individual psychotherapy**  **Family group of 2 or more – Child present?  Yes  No**  **Group Psychotherapy with unrelated individuals**  *Please explain why the client cannot receive services through Medicaid, insurance, or paying a sliding scale fee. Also explain why the client must receive services from a Psychologist, and not through a Master Level Clinician under the Professional Services contract.* | 15 hours over a 3 month period (15hrs/3month) |  |
|  | **Professional Consultations with DCYF staff or other authorized parties with report** | 15hrs/3 month |  |
|  | **Case Related Travel** | Preauthorization from a PM required above 1hour |  |

**The provider is required to have a written contract with DCYF in order to provide referred services.  Rates must be as agreed upon in the contract for reimbursement.**

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

Caseworker Signature Date

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

Supervisor Signature Date

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

Area Administrator Signature Date

**\*\*\*\* PRESENTING ISSUES & TREATMENT GOALS FOR CLIENT ON NEXT PAGE \*\*\*\***

**Identified Client** (name):

|  |
| --- |
| **Presenting Issues & Treatment Goals**  *DCYF staff referring a client for services must clearly articulate the need for this service as it relates to child safety and/or well-being, and the permanency planning goals of the case. If details including specific questions or topic to be addressed in the evaluation or counseling sessions are provided here, a separate referral letter to the provider is unnecessary.* |
| ***Presenting Issues***    ***Goals*** *for Counseling or Treatment* |
| **Supporting Documentation**  *Referring DCYF staff must attach all relevant information needed to assist the provider in the evaluation or treatment of the client. Check the boxes next to the attachments that accompany this referral.* |
| Intake/Referral  Investigative Assessment  Psychological Evaluation  Court Report  Visitation Reports  Parenting Assessment  Medical Records  Substance Use Disorder Evaluation  Other: |

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

*Social Worker Signature Date*