Pathways, Inc.

Pathways, Inc.
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 _____ Plan ID _____

Member ICD-10 Diagnosis Code(s) :

Status: Tier I _____ Tier II _____

Health Home _____

Health Home Care Manager _____

Phone _____ Email _____

Adult BH HCBS requested

Please select the Adult BH HCBS for which authorization is requested (no more than 3 per request):

- ☐ Education Support Services
- ☐ Peer Supports
- ☐ Pre-vocational Services
- ☐ Ongoing Supported Employment
- ☐ Psychosocial Rehabilitation (PSR)
- ☐ Habilitation
- ☐ Family Support and Training (FST)
- ☐ Intensive Supported Employment (ISE)

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 all Adult BH HCBS requested above

_____ Signature of Provider

_____ _____ _____
Name (please print): Title Date

Date Received _____
(for business office use only)

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