Children's Services Act (CSA) Referral for Residential Treatment Services

The top portion of the form is to be completed by the Authorized CSA; once completed, please forward to the Residential Treatment Provider to complete the bottom portion of the form.

Name of Youth:			
Medicaid Number:			
Residential Treatment Provide	r:		
Name of Locality:		FIPS/CSA Lo	cality Code:
I certify that this youth has been Therapeutic Group Hom Treatment (EPSDT) TGHs)	•		Diagnostic and
Psychiatric Residential	Treatment Facility Se	ervices (this includes EPSDT	PRTFs)
Effective Date of Residential Ad	mission:		
This youth is in the custody of the eligible for title IV-E	e local department of	f social services and has	been determined
Yes			
No			
For Medicaid members, CSA ma	y not pay for any ser	vice that can be funded	through Medicaid.
	Authorized CS	A Signature:	
	Print Name: _		
	Title:		
	Date:		
For Provider Use Only Once this portion is complete, please for	orward to the Service Au	thorization Contractor	
NPI:			
Provider Address:	Street		
City		State	ZIP