

Referral Information

*required information

1. Youth Full Legal Name*: _____

2. Date of Birth*: _____

3. Parent/Guardian Full Names*: _____

5. Phone*: _____

6. Email (Parent/Guardian)*: _____

7. Parent/Guardian Full Address*: _____

8. Race (Youth)*: _____

9. Primary Care Physician (if known)*: _____

10. Therapist/Mental Health Provider: _____

11. Medicaid number*: _____

12. Axis 1 Mental Health Diagnosis*: _____

13. CASII Assessment (attach score sheet & assessment): _____

Referred by: _____

Date: _____

PLEASE COMPLETE WITH AVAILABLE INFORMATION AND RETURN TO: WYClinical@MagellanHealth.com

Please call us at 1-855-883-8740 if you have any questions.

Exclusions

A child or youth will not qualify for wraparound if he or she is:

- Already on or qualifies for the Developmental Disabilities Waiver
- Already on the Compensated Care Waiver
- On Long Term Disability

Please note

A child or youth is eligible for High Fidelity Wraparound services if he or she is Medicaid eligible or are determined to be Medicaid eligible through a waiver.

For a complete list of eligibility requirements, visit www.MagellanofWyoming.com