Email to:
Harris Quality Care Services
sharris@harrisqualitycare.com

Harris Quality Care Services
Community Engagement/Community Coaching Referral Packet

Please submit the following information when requesting services through the FIS and CL Medicaid Waiver.

Individual's Name: _____ D.O.B_____

Address:

_____

Medicaid #:

_____

ISP Dates: _____ TO _____ Quarterly Dates: _____

Diagnoses:

_____

_____

_____

Brief Reason for Referral:

_____

_____

_____

Support Coordinator's Name: _____

CSB: _____

Phone #: _____ Fax #: _____

E-mail: _____

Residential/Home Contact: Phone: _____

Day Program/Work Contact: Phone: _____

The following documents must be included:

- ☐ ISP; Parts 1-4
- ☐ Psychological Evaluation
- ☐ Physical Examination
- ☐ PPD (TB Screen within 30 days)
- ☐ VIDES and SIS
- ☐ Annual Risk Assessment and RAT
- ☐ Choice of Medicaid form
- ☐ Release/disclosure form
- ☐ Guardian/POA (if applicable)