6200 Aurora Ave Ste 400W
Urbandale, IA 50322
Phone: (515) 274-9607

Name: ______________________
MR # ______________________
WCBS Staff: ________________

Woodward Community Based Services
Referral Form

☐ **SCL – BI/ID Waiver** ☐ **HBH HOURLY** ☐ **HBH DAILY**

Please provide social history and most recent service plan with referral form.

Name:______________________ DOB:__________ Age: _____ Gender:______ Race:________ Title XIX:__________

SS#:_______________ Religion:_____________ Preferred Language/Communication:______________ School/Employer:___________

Current placement/residence:__________________________Address:______________________________________

Phone number: ____________________________Email:______________________________________

Guardian(s)_________________________ Address:______________________________________

Phone:______________________________ Preferred Language:___________________Email:_______________________________

Mother: ____________________________ Phone ______________________Address:__________________________________

Father: ____________________________ Phone _____________________Address:__________________________________

Emergency Contact:___________________ Phone ____________________Relationship to Member:_________________________

Referral Source:______________________ Phone ( )______________________Agency______________________________
Funding Source?: ______________________ Private Pay?:__________ Sliding Fee Scale?:___________________

Medical Conditions: ____
Impairments (If Any): ___________________________________ Allergies: ___________________________________
Medications:____
Mental Health Diagnosis:____
Expected tier level/weekly service hours (Hourly/SCL): ______________________________________

Insurance Information

Please provide a copy of your insurance card(s) prior to your appointment by sending it to madison.bates@wcbscares.com or bring a copy with you for your intake.

Primary Insurance Coverage: __________________________________Phone Number: ____________________________
Name of Insured: ____Insured DOB: ____/_____/__________
Relationship to Insured: ____________________________ Insured Employer: ____________________________________
Policy #:____ Group #:____
Effective Date: ____/____/________

Secondary Insurance Coverage: ________________________________Phone Number: ____________________________
Name of Insured: ____Insured DOB: ____/_____/__________
Relationship to Insured: ____________________________ Insured Employer: ____________________________________
Policy #:____ Group #:____
Effective Date: ____/____/________