MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

CHILDREN'S TREATMENT SERVICES (CTS)/MEDICAID REFERRAL SUMMARY

CLIENT NAME	DCN
ER	DATE
CHILDREN'S SERVICES WORKER	TYPE OF REFERRAL (PLEASE ATTACH COPIES OF MXIX, MCII AND MTPR SCREENS) ☐ CTS ☐ MEDICAID
IS CLIENT COVERED BY PRIVATE INSURANCE? ☐ YES ☐ NO	NAME OF PRIVATE INSURANCE COMPANY
ADDRESS	TELEPHONE NUMBER

BRIEFLY SUMMARIZE THE FOLLOWING:

1. Relevant background information on this family.

2. History of DFS involvement.

3. Description of presenting problems.

4. Summary of treatment goals for this family.

5. Expected outcomes of intervention.

6. Plan for ongoing sharing of information and service coordination during the delivery process.

RVICE INFORMATION (TO BE COMPLETED BY PROVIDER)

F SERVICE	TYPE(S) OF SERVICE
FREQUENCY	PROVIDERS SIGNATURE