



## Neuropsychological Services Referral

This authorization is valid for up to 180 days from the date of this referral

Date of Referral \_\_\_\_\_

Starting Date \_\_\_\_\_

Ending Date \_\_\_\_\_

Provider Name \_\_\_\_\_

FamLink Provider ID \_\_\_\_\_

DCYF Caseworker \_\_\_\_\_

Phone Number \_\_\_\_\_

DCYF Office \_\_\_\_\_

FamLink Case ID \_\_\_\_\_

Client's Name \_\_\_\_\_

Client's Phone Number \_\_\_\_\_

Caregiver Name of Children \_\_\_\_\_

**Allowed Hours & Rates** are posted at

<https://www.dcyf.wa.gov/sites/default/files/pdf/fee-NeuroPsychServices.pdf>. If DCYF is paying for the evaluation or a specific month of counseling, providers cannot accept other funding.

	Service Requested	Maximum Hours	Hours Authorized
	<b>Neuropsychological Evaluation</b> (Testing with interpretation and report)	12 hours	
	<b>Parenting Evaluation / Parenting Component</b> (Conducted in addition to the work done under the Neuropsychological Evaluation above)	Up to 5 additional hours	
	<b>Psychotherapy with written report</b> <b>Individual psychotherapy</b> <b>Family group of 2 or more – Child present?    Yes    No</b> <b>Group Psychotherapy with unrelated individuals</b> <i>Please explain why the client cannot receive services through Medicaid, insurance, or paying a sliding scale fee. Also explain why the client must receive services from a Psychologist, and not through a Master Level Clinician under the Professional Services contract.</i>	15 hours over a 3-month period (15hrs/3month)	
	<b>Professional Consultations with DCYF staff or other authorized parties with report</b>	15hrs/3 month	
	<b>Case Related Travel</b>	Preauthorization from a regional PM required above 1 hour	

### Signatures

Required	Signature	Print Name	Date
Regional PM (for travel over 1 hour)			
Social Worker			
Supervisor			
Area Administrator			

Identified Client Name \_\_\_\_\_

### Presenting Issues & Treatment Goals

DCYF staff referring a client for services must clearly articulate the need for this service as it relates to child safety and/or well-being, and the permanency planning goals of the case. If details including specific questions or topic to be addressed in the evaluation or counseling sessions are provided here, a separate referral letter to the provider is unnecessary.

### Presenting Issues

### Goals for Counseling or Treatment

### Supporting Documentation

Referring DCYF staff must attach all relevant information needed to assist the provider in the evaluation or treatment of the client. Check the boxes next to the attachments that accompany this referral.

- |   |  |
|---|--|
| <input type="checkbox"/> Intake/Referral          | <input type="checkbox"/> Visitation Reports                |
| <input type="checkbox"/> Investigative Assessment | <input type="checkbox"/> Parenting Assessment              |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Medical Records                   |
| <input type="checkbox"/> Court Report             | <input type="checkbox"/> Substance Use Disorder Evaluation |
| <input type="checkbox"/> Other _____              |  |