

PSYCHOLOGICAL SERVICES REFERRAL

DATE OF
REFERRAL

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

Starting Date		Ending Date	
Provider Name		FamLink Provider ID	
DCYF Caseworker		Phone Number	
DCYF Office		FamLink Case ID	
Client's Name (For Children also give caregiver's name)		Client's Phone Number	

Allowed Hours & Rates are posted at <https://www.dcyf.wa.gov/sites/default/files/pdf/Fee-PsychologicalServices.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
Psychological Evaluation (Testing with interpretation and report)	10 hours	
Neuropsychological testing battery & neurobehavioral status exam with interpretation & report – (Conducted in addition to the work done under the Psychological Evaluation above)	2 additional hours	
Parenting Evaluation / Parenting Component (Conducted in addition to the work done under the Psychological Evaluation above)	Up to 5 additional hours	
Psychotherapy with written report <input type="checkbox"/> Individual psychotherapy <input type="checkbox"/> Family group of 2 or more – Child present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Group Psychotherapy with unrelated individuals <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)	
Professional Consultations with DCYF staff or other authorized parties with report	15hrs/3 month	
Case Related Travel	Preauthorization from a regional PM required above 1hour	

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

**** PRESENTING ISSUES & TREATMENT GOALS FOR CLIENT ON NEXT PAGE ****

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.

- Intake/Referral Investigative Assessment Psychological Evaluation Court Report Visitation Reports
- Parenting Assessment Medical Records Substance Use Disorder Evaluation
- Other: