**Referral Reason: DYS/ Community Based Program Independent Assessment Request**

**Custodian:**

**First Name: Middle Initial: Last Name:**

**Medicaid ID:**

**SSN: DOB:**  **AGE: Gender:** Choose an item.

**Name of Guardian:** Click or tap here to enter text.

**Guardian Phone Number:** Click or tap here to enter text.

**Mailing Address of Guardian**

**Street Address:**

**City: State: AR Zip Code: County:**

**Behavioral Health/Mental Health Provider:**

**Behavioral Health/Mental Health Diagnosis:**

**DYS Information:**

**JPO or CBP Contact:**

**Contact Number:**

**Contact Email:**

**Mailing Address (address, city, & zip):**

**Describe Behavioral Health Symptoms and Functional Status indicating need for assessment?**

**Please submit this form to:** [**DAABH.HospitalIA@dhs.arkansas.gov**](mailto:DAABH.HospitalIA@dhs.arkansas.gov)