JUVENILE REHABILITATION (JR)

Medical Services Authorization

New Case

JR ACT ID NUMBER	JR REGION NUMBER (EXAMPLE: JR REGION 1)

FACILITY NAME	FACILTY PHONE NUMBER (INCLUDE AREA CODE)

FACILITY MAILING ADDRESS (WHERE MED ID WILL BE MAILED)	CITY	STATE	ZIP CODE
		WA	

JR Youth

FULL NAME OF JR YOUTH	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	SEX	US CITIZEN
			☐ Male ☐ Female	☐ Yes ☐ No

CF TRANSITION DATES

INTAKE: _____ RELEASED FROM FACILITY _____

PRIVATE INSURANCE	NAME OF PARENT / SUBSCRIBER INSURING YOUTH	INSURANCE ID NUMBER
☐ Yes ☐ No		

PRIMARY INSURANCE COMPANY'S NAME	PROVIDER ONE NUMBER

Recommended By

I recommend the above youth to be medically eligible based upon his/her placement in this JR group home.

PRINTED NAME OF PERSON COMPLETING FORM	DATE

CF TRANSITION DATES

INTAKE: _____ RELEASED FROM FACILITY _____

Transfer, Release, or Discharge

MEDICAL LIAISON AUTHORIZATION SIGNATURE	DATE	PRINTED NAME OF MEDICAL LIAISON

TRANSFER, RELEASE, OR DISCHARGE TO:

☐ Self ☐ Parent(s) ☐ Community Facility ☐ Institution

☐ Division of Children and Family Services (DCFS) care / group home

☐ Other:

YOUTH MAILING / STREET ADDRESS FOR PAROLE	CITY	STATE	ZIP CODE

YOUTH RELEASE PHONE NUMBER (INCLUDE AREA CODE) FOR PAROLE

NOTES