This space for use by Ryan White Part A Agency RECEIVING referral only:

Start Date: _____ Stop Date*:_____ Client CIS#: _____

*(*NOTE: Maximum length of time for each Out of Network / Non-Certified Referrals is 6 months.)*

OUT OF NETWORK (OON) / NON-CERTIFIED REFERRAL

for Miami-Dade County Ryan White Part A/MAI Program Services

This form along with copies of required client eligibility documentation are required for EACH OON or Non-Certified Referral to Miami-Dade County Ryan White Part A/MAI Program services. See the accompanying "Client Eligibility Documentation Checklist for Miami-Dade County Ryan White Program Services" for a list of acceptable documents and special eligibility rules. Proof that the Ryan White Part A Program is PAYER OF LAST RESORT is also required.

Note to Ryan White Part A/MAI Service Providers: Upon receipt of this form and required documentation – and prior to rendering services, a current, signed, and dated SDIS Authorization for the Release and Exchange of Information, Composite Consent, and a Miami-Dade County Notice of Privacy Practices must be signed by the client and a Part A/MAI agency representative. These documents must be maintained in the client's chart.

REFERRAL FROM: (*Select One: Client Self-referred or Other*)

_____ Client self-referred

_____ Other (case manager, care manager, etc.). Please specify:

Name: _____ Position Title: _____

Agency Name: _____

Phone: _____ Fax: _____

REFERRAL TO:

(See last page of Client Eligibility Documentation Checklist for a list of available services, including special income criteria.)

Please list the needed service(s) below:

_____ Core Medical Service [Specify service(s) needed: _____]

_____ Support Service [Specify service(s) needed: _____]

Ryan White Part A Service Provider (Agency Name):_____

Phone: _____ Fax: _____

Special Instructions: _____

CLIENT INFORMATION:

Name: _____ DOB: ____/____/____ Social Security #: _____/____/_____

Street Address_____City_____Zip_____

Phone: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

INSURANCE OR BENEFIT PROGRAM INFORMATION:

Medicaid ID#: _____ Medicare ID#:_____

- Managed Medical Assistance (MMA) Plan Name: _____

- Long Term Care (LTC) Plan Name: _____

Private Insurance ID# & Plan Name: _____

Ryan White Part: ____B ____C ___D

I attest that all documentation provided with this referral is complete, accurate, and true. I consent to this referral for services to be provided by the Miami-Dade County Ryan White Part A Program.

Client Signature: (required) _____ Date ___/___/___

Agency Representative's Signature: (if applicable) _____