Special Health Care Needs
Brain Injury Waiver Program Referral

DEMOGRAPHICS					
PARTICIPANT NAME: (LAST, FIRST, MIDDLE)		**DCN:**	**MO HEALTHNET STATUS:** ☐ Fee for Service ☐ Managed Care		**DATE:**
DOB:	**SEX:**	**RACE:**	**ME CODE:**	**OTHER INSURANCE:**	
RESPONSIBLE PARTY:		**RESPONSIBLE PARTY SSN:**		**RELATIONSHIP:**	
ADDRESS:				**COUNTY:**	
CITY:		**STATE:**		**ZIP:**	
EMAIL ADDRESS:		**HOME PHONE:**		**WORK PHONE/MESSAGE PHONE:**	

REFERRAL INFORMATION	
AGENCY:	**CONTACT:**
PHONE NUMBER:	**FAX NUMBER:**

MEDICAL INFORMATION			
DIAGNOSIS:	**ICD10 CODE**	**SERVICES TO BE PROVIDED:**	
	ICD10 CODE		
	ICD10 CODE		
	ICD10 CODE	**START DATE:**	**STOP DATE:**
PHYSICIAN ORDERING SERVICES:		**PHYSICIAN PHONE NUMBER:**	

ADDITIONAL INFORMATION

FOR SHCN OFFICE USE ONLY:	
RECEIVED BY:	**DATE:**
GIVEN TO:	**DATE:**

Please fax the completed form to:

Bureau of Special Health Care Needs
Jefferson City
920 Wildwood Dr Jefferson City, Mo
Phone: (573) 751-1651 Fax: (573) 552-9583