IBHS Inquiry for Services

Please fully complete this form and email it to Central.AccessVoicemailFax@wfspa.org or fax it to 412-347-3237
If we have staff available we will follow up with you. If you wish to email, WFS cannot safely guarantee your information will not be compromised.

Client Information:

Age:	**Gender:**	**City Location:**

Written Order completed? ☐No ☐Yes- Date: _____
(If no, please obtain Written Order before making referral.)

Written Order completed by: _____
Promise ID: _____

How many hours prescribed (Non-ABA):
☐BC _____ ☐MT _____
☐BHT _____

How many hours prescribed (ABA):
☐BC-ABA _____ ☐BHT-ABA _____
☐BA _____ ☐ABC-ABA _____

Family okay with BC or MT only? (No BHT)
☐No ☐Yes

Diagnosis:

Transfer Case:
☐No ☐Yes: Explain_____

Insurance coverage (check all that apply):
☐ MA/FFS ☐CCBHO ☐Commercial ☐HSAO ☐CHIP ☐MA Pending
If commercial, what provider? _____

Family Availability: (Please provide specific times or we will be unable to check on staff)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning Hours							
Afternoon Hours							
Evening Hours							

If the services are wanted in school or daycare, what is the name? _____

Referral Source:

Date:	Name:
Phone Number/Email:	Agency:

Additional Comments:
