

Child's name: _____ MAID #: _____ Today's date: _____

Please choose the in network provider you wish to receive BHR services from if these services are approved. Each provider that is in network and approved by the county where you/your child's Medical Assistance is registered is listed. Circle to clearly indicate choice- note age ranges. **NOTE: If you have primary commercial insurance and the services are for Autism Spectrum Disorder, these services may be covered under Pa. Act 62. Please check with your primary insurance for coverage and choose a provider who participates in your commercial insurance network and PerformCare.**

Franklin/Fulton	Ages
^ ~ Achieving True Self P: 866-287-2036 F: 888-244-1718	0-21
~ Children's Behavioral Health P: 814-623-1051 F: 814-623-1895	0-21
~ Family Behavioral Resources Fulton P: 717-325-0223 Fulton F: 717-325-0228 + Franklin P: 717-496-8127 Franklin F: 717-504-8962	0-21
~ Laurel Life Services P: 717-375-1516 F: 717-263-6049	3-21
~ Momentum Services P: 717-262-2183 F: 717-262-2486	0-21
~ PA Counseling P: 717-261-1218 F: 717-263-6571	0-21
~ Youth Advocate Programs P: 717-267-7887 F: 717-267-0787	0-21

^ Indicates Providers who only provide ABA services

~ Indicates Providers who provide ABA services

+ Indicates Providers that have Spanish speaking staff (availability may be limited)

BHRS Treatment Recommendations (check, if known)		
BSC	MT	TSS

Member contact information (Member & Parent/Guardian name/contact #): _____ Member diagnosis: _____

Special needs of Member (i.e. hearing-impaired, seeing-impaired, ESL): _____

To which Provider was referral information sent: _____

Member/Parent/Guardian signature: _____ Date: _____