ARLINGTON
VIRGINIA

VENDOR MATCHING REQUEST FORM

CHILD'S INFORMATION

First Name: __________________ Last Name: __________________

Date of Birth: __________________ Race: __________________

Ethnicity: __________________

Sex Assigned at Birth: __________________ Gender Identity: __________________

Primary Insurance: __________________ Secondary Insurance: __________________

Uninsured: ☐

Cultural Considerations (i.e. language spoken in the home): __________________________

Services Requested for Matching: __________________

The youth and family are agreeable to services: ☐ Yes ☐ No

CASE INFORMATION

DIAGNOSIS: ____

PRESCRIBED PSYCHOTROPIC MEDICATION: ____

____

SYMPTOMS:

ACUITY: ☐ Mild ☐ Moderate ☐ Severe

PREVIOUS INTERVENTIONS:

CURRENT SERVICES:

Assigned Utilization Review Staff: ____

RECOMMENDATIONS FOR MATCHING (to include available vendors only):

Date of Recommendations Provided to Requesting Staff: ___________________