FOR ACO/MCO INTERNAL USE ONLY
Date Received: Click here to enter a date.
Date the Referral was Denied/Approved: Click here to enter a date.

MASSHEALTH COMMUNITY PARTNERS PROGRAM REFERRAL INTAKE FORM

Please send this intake form to the specified central point of contact for CP program referrals at the member's ACO/MCO. If you are unsure of the member's ACO/MCO, please contact **MassHealth's Customer Service Center** at 800-841-2900 with the member. The member must be present when contacting the Customer Service Center on their behalf.

REFERRED MEMBER INFORMATION		
Name *(Last, First, M.I.):* Click here to enter text. ☐ M ☐ F ☐ Non-Binary		**DOB:** Click here to enter a date.
MassHealth Identification Number (if known): Click here to enter text.	**Member's address:** Click here to enter text.	
Member's primary language: Click here to enter text.	**Member's legal guardian name and phone number (if applicable):** Click here to enter text.	
Member's ACO/MCO (if known): Click here to enter text.	**Member's phone number:** Click here to enter text.	
Member's primary care physician: Click here to enter text.	**Member's primary care physician's phone number:** Click here to enter text.	
Member's primary medical/behavioral health/LTSS-related diagnosis: Click here to enter text.		
Reason(s) for Referral: Click here to enter text.	**Contact information for agencies currently involved in member's care:** Click here to enter text.	

REFERRAL SOURCE INFORMATION
Referral Source's Name: Click here to enter text.
Referral Source's organization/agency: Click here to enter text.
Referral Source's phone number: Click here to enter text.
Signature of Referral Source: Click here to enter text.