



WASHINGTON COUNTY
Oregon

Intensive Service Array (ISA)
Referral for Eligibility Determination

Client Name: _____ OHP# _____

Date of Birth: _____ Referred by: _____

Phone: _____ Fax: _____

Guardian Information (MUST BE INCLUDED):

Name: _____ Relationship: _____

Address: _____

Phone: _____

Providers, Educators, DHS and Juvenile Justice should submit the most recent clinical documentation indicating the need for participation in the Intensive Service Array.

WCHHS USE ONLY

Date of Initial Request for ISA Screening: _____

Additional information needed? Y / N Date Requested: _____

Date Referral complete: _____ Date of Eligibility Determination: _____

ISA eligible? Y / N Referral Source Notified? Y / N Family Notified? Y / N

MCO Open Card Commercial GF Other: _____

Dx: _____

Ethnicity: White African American Hispanic Asian Native American

Other _____

Signature of Person conducting determination: _____