DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Care Financing and Policy
Helping people. It's who we are and what we do.

Referrals for 1915(i) Program

Date _____

1. Select the Service

Only for Individuals with Traumatic Brain Injury or Acquired Brain Injury

☐ Adult Day Health ☐ Day Habilitation ☐ Residential Habilitation

2. Recipient Information

Last Name _____ First Name _____ Initial _____

Date of Birth _____ Medicaid ID _____

Address _____

City/State/Zip Code _____

Home Phone _____ Cell Phone _____

Email _____ Preferred Language _____

3. Designated Representative (if applicable)

Name _____

Address _____

City/State/Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

4. Referring Individual Information

Name _____ Organization _____

Address _____

City/State/Zip Code _____

Contact Number _____ Cell Phone _____

Email _____

5. Documents Required (please attach)

☐ History and Physical within past 6 months ☐ Documentation of TB test within past 12 months ☐ Doctor's Orders (if applicable)

☐ For Day Habilitation and Residential Habilitation Services- medical documentation signed by a physician indicating a Traumatic Brain Injury or Acquired Brain Injury

6. Submitting Referral

A complete referral packet, including this form and all required documents, can be submitted to one of the following:

- Email: 1915i@dhcfp.nv.gov Fax: (775) 687-8724
- In-Person: 1210 S. Valley View Blvd, Ste. 104, Las Vegas, NV 89102

Questions call (702) 668-4200