Phone: 828-438-6218

Repay, Inc.

Fax: 828-439-2340

Sexual Abuse Intervention Services

Referral Form

Referring Agency: _____ Referring Agency Contact: _____

Referring Agency County: _____ Referring Agency Phone: _____

Referring Agency Medicaid#: _____ Referring Agency Fax: _____

Referring Agency NPI# _____ Client/Guardian Phone: _____

Date of Referral: _____ Reason for Referral: _____

Adult ☐

Adult's name: _____

***Adult's date of birth: *(MANDATORY)** _____ ***Social Security No. *(MANDATORY)** _____

County of Residence: _____

Client Phone Number _____

Pending Legal Charges?: Yes ☐ _____

No ☐ _____

Adjudicated: Yes ☐ _____

No ☐ _____

Third Party Coverage: *Medicaid ☐ Number: _____

Medicare ☐ Number: _____

Insurance Type/Policy Holder/ID No./Grp No: _____

Other ☐ _____

(IPRS,JCPC, Federal ☐ ion, Etc.)

Brief Narrative: _____

**Please allow 24 hours response time to your referral and 10 working days for an appointment with SAIS Treatment Program.*

FOR SAIS OFFICE USE ONLY

The following determination of the above referral was made:

Date Referral Rcv'd: _____ Date Replied To: _____ Service _____

Accepted ☐ Time: _____ Date: _____ Initial Cost (if applic): _____

Other ☐ Mailing address: _____