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Kern Regional Center Referral Form

Service Coordinator:

Today's Date: _____

Client Name:

UCI#:

DOB:

Guardian Name:

Guardian Phone:

Guardian Email:

Dates of Authorized Service: Start

End

Is this client at-risk for, or have, a diagnosis of Autism, with early language needs?

Yes No

Select Service: All services require multiple sub codes. Please ensure that each sub code listed is authorized. This will prevent any delays in services.

BMOD **EIBT** - Behavior Management Assessment: Appropriate for anyone of any age who is in need of behavioral services including young children at-risk, or diagnosed with, Autism needing Early Intensive Behavior Intervention (EIBT).

Behavior Management: Vendor #PT0279 Service Code 620

Sub Code: ASSMT Hours: 10 Total

Sub Code: OOO Units: Unlimited

Sub Code: Trans Units: Unlimited

Please email complete referral packet to: ClientServices@Holdsambeck.com

Adaptive Skills Training: Adaptive or Social Skills Assessment: Appropriate for anyone of any age who would benefit from Adaptive or Social Skills.

Adaptive & Social Skills: Vendor #PT0426 Service Code 605

Sub Code: ASSMT Hours: 10 Total

Sub Code: OOO Units: Unlimited

Sub Code: Trans Units: Unlimited

Please email complete referral packet to: ClientServices@Holdsambeck.com

16-Hour Online Group Parent Training, by Behavioral Consultation

Vendor #: PT1043 Service Code: 102

Sub Code: 16-Hour Online Group Parent Training- 1 Unit

Please email face sheet to: BehavioralConsultation@gmail.com