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Medicaid Managed Care Referral Form

INSTRUCTIONS: Please complete sections A, B, C, D and E for all referrals in addition to the services section the child is being referred to.

A. REFERRAL DEMOGRAPHICS:

CHILD'S NAME (LAST, FIRST MI):		DATE OF BIRTH:	GENDER: ☐Male ☐Female ☐ Other
INSURANCE CARRIER:	MEDICAID CIN/INSURANCE #:	FOSTER CARE STATUS: ☐Current ☐Past ☐None	ETHNICITY:
CAREGIVER NAME:	PHONE NUMBER: IS TEXTING PREFERRED? ☐ Yes ☐ No	BEST TIME TO CONTACT:	
EMAIL:			
ADDRESS (INCLUDE CITY, STATE, ZIP CODE):			

B.CONSENT TO REFER: Consent must be obtained from the parent/guardian/legally authorized representative for children until the age of 18. Youth ages 18-21, that are married, a parent, or pregnant may provide consent on their own behalf.

CONSENTERS NAME (if different than above):	PHONE NUMBER: IS TEXTING PREFERRED? ☐ Yes ☐ No	BEST TIME TO CONTACT:
EMAIL:		
ADDRESS (INCLUDE CITY, STATE, ZIP CODE):		
RELATIONSHIP TO YOUTH/CHILD: ☐Parent ☐ Guardian ☐Legally Authorized Representative ☐ Youth 18 or over ☐Youth (parent) ☐ Youth (pregnant) ☐Youth (married)		

C. REFERRAL SOURCE:

REFERRING INDIVIDUAL, TITLE, AGENCY:		DATE OF REFERRAL:
ADDRESS (INCLUDE CITY, STATE, ZIP CODE):	EMAIL:	PHONE #: FAX #:
HOW DID YOU HEAR ABOUT ELMCREST SERVICES: ☐Presentation ☐ Word of Mouth ☐Website/advertisement ☐ Insurance Company ☐State Agency ☐CHUNNY ☐Other: _____		

D. CURRENT SERVICES & DIAGNOSES:

WITH WHICH OF THE FOLLOWING AGENCIES IS THE CHILD INVOLVED OR RECEIVING SERVICES? (CHECK ALL THAT APPLY)

☐Mental Health Agency/Clinic/Provider
☐Physical Health Care Agency/Clinic Provider
☐Substance Abuse Agency/Clinic/Provider
☐Intellectual Disabilities Agency/Clinic/Provider
☐School/Educational Facility/Staff
☐Early Intervention
☐Child's parent currently enrolled in the Health Home Program

☐Child Welfare/Child Protective Services
☐Preventative Services
☐Family Court
☐Juvenile Court/Corrections/Probation/Police
☐Kinship Care
☐Inpatient Facility, if yes, Name of facility: _____
Expected discharge date: _____
☐Other: _____

WHAT IS THE CHILD'S CLINICAL DIAGNOSIS? (COMPLETE IF KNOWN)

	ICD-10/DSM-V Code	Diagnosis Name
Primary Diagnosis	_____	_____
Secondary Diagnosis	_____	_____
Additional Diagnosis	_____	_____

Assigned by:
Date/Location of Evaluation:

E.SUPPORTIVE INFORMATION:

DESIRED OUTCOME FOR SERVICES:

CHILD & FAMILY STRENGTHS/INTERESTS/HOBBIES/ACTIVITIES:

ADDITIONAL INFORMATION:

NAME:
DOB:

Complete section F and G to make a

Care Management Referral:

F. ELIGIBILITY: Check Category child is being referred through

☐ **Two or more Chronic Conditions (Categories include: Developmental Disabilities, Medical Conditions, Substance Use Disorders and Other)**
List Qualifying Chronic Conditions: _____

☐ **Serious Emotional Disturbance (SED): AND** has experienced functional limitations due to diagnosis over the past 12 months (from the date of assessment) on a continuous or intermittent basis in ONE or more of the following areas: Ability to care for self, Family life , Social relationships, Self-direction/self-control and/or Ability to learn

☐ **Complex Trauma: *single qualifying condition*** Note – If this is the only box checked on the form you must ALSO complete the Complex Trauma Referral Cover Sheet and the Complex Trauma Exposure Screen and attach with the referral form.

☐ **HIV/AIDS**

G. RISK FACTORS: Check All that Apply and Provide Explanation of How Child/Youth Exhibits Risk Factors

☐ **At risk for adverse event** (e.g. death, disability, inpatient admission, mandated preventive services, or out of home placement);
☐ **Has inadequate social/family/housing support, or serious disruptions in family relationships;**
☐ **Has inadequate connectivity with healthcare system;**
☐ **Does not adhere to treatments or has difficulty managing medications;**
☐ **Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;**
☐ **Has deficits in activities of daily living, learning or cognition issues; OR**
☐ **Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home**

Explanation of exhibited risk factors: _____

Complete section H to make a

Child and Family Treatment and Support Services (CFTSS) or Syracuse Psychological Services Referral:

H. ASSESSMENT FOR SERVICE NEEDS: What behaviors initiated the referral for services (Check all that apply)

☐Conduct/delinquency-related behaviors (physical aggression, extreme verbal abuse, non-compliance, property damage, theft, running away, fire setting, cruelty to animals, truancy, police contact)	☐Disordered eating (including anorexia, bulimia)
☐Hyperactive and attention-related behaviors	☐Sleeping problems
☐School/educational performance	☐Maltreatment (child abuse and neglect)
☐Depression	☐Excessive crying/tantrums
☐Anxiety	☐Persistent noncompliance
☐Adjustment-related issues (to significant life stress)	☐Pervasive developmental disabilities (extreme social avoidance, stereotypes, perseverative behavior)
☐Suicide-related thoughts or actions	☐Specific developmental disabilities (enuresis, encopresis, expressive or receptive speech and language delay)
☐Self-injury	☐Separation/attachment problems
☐Sexual behavior problems, sexual assault	☐Feeding problems (failure to thrive)
☐Psychotic behaviors (hallucinations, delusions, strange/odd behavior)	☐Other concerns related to health of child (cancer, illness, or disease related problems)
☐Substance use, abuse, and drug dependency	☐Excluded from school/childcare due to behavioral or developmental problems
☐Intellectual disabilities	☐Other: _____
☐Learning disabilities	

*NOTE: all HBCS Referrals MUST come from a Care Manager or Independent Entity: Complete section I to make a

Home and Community Based Services (HCBS) Referral:

I. SERVICES AND NEEDS: Check all support services being requested. Please note any known scheduling or staffing needs or preferences.

Services: ☐ Caregiver/Family Supports and Services ☐ Community Self-Advocacy Training and Supports ☐ Respite ☐ Community Habilitation ☐ Prevocational Services/Supported Employment
Staffing Needs/Preferences (e.g. male or female, easy going- strict):
Scheduling Needs/Preferences (e.g. not available on weekends, child returns from school at 2 pm):

PLEASE SUBMIT ALL REFERRALS AND REFERRAL INQUIRES TO:
Director of Admissions, Medicaid Managed Care Services:
Brianna Dewhirst
Email: Bdewhirst@Elmcrest.org **Office: 315-446-6250 x 11** **Cell: 315-569-9739** **Fax: 315-295-1888**
960 Salt Springs Road, Syracuse New York 13224

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Children & Family Treatment & Support Services (CFTSS)
External Provider Medical Necessity Recommendation Documentation

Youth's Name: _____ Youth's Medicaid Number: _____

Diagnosis (ICD -10-CM): _____ ICD-10 (F Code): _____

Diagnosis Date: _____

I, the undersigned, based on my assessment of need and review of records have determined that the above referenced youth meets medical necessity and would benefit from the provision of the following Children & Family Treatment & Support Service:

☐ **Other Licensed Professional (OLP)**

The above named youth meets the Medical Necessity for OLP based on at least one of the following criteria:

☐ OLP is necessary to correct or ameliorate conditions that are found through an EPSDT screening.

☐ OLP addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

Licensed Practitioner of the Healing Arts (LPHA):

_____ _____
Signature & Title Printed Name

_____ _____
NPI # Date

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Children & Family Treatment & Support Services (CFTSS)
External Provider Medical Necessity Recommendation Documentation

Youth's Name: _____ Youth's Medicaid Number: _____

Diagnosis (ICD -10-CM): _____ ICD-10 (F Code): _____

Diagnosis Date: _____

I, the undersigned, based on my assessment of need and review of records have determined that the above referenced youth meets medical necessity and would benefit from the provision of the following Children & Family Treatment & Support Service:

☐ **Community Psychiatric Supports & Treatment (CPST):**

The above named youth meets the Medical Necessity for CPST based on **ALL** three of following criteria:

☐ The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the youth is at risk of development of a behavioral health diagnosis **AND**

☐ The youth is expected to achieve skill restoration in one of the following areas:
- Participation in community activities and/or positive peer support networks
- Personal relationships
- Personal safety and/or self-regulation
- Independence/Productivity
- Daily Living Skills
- Symptom Management
- Coping strategies and effective functioning in the home, school, social or work environment **AND**

☐ The youth is likely to benefit from and respond to the services to prevent the onset or the worsening of symptoms.

Licensed Practitioner of the Healing Arts (LPHA):

_____ _____
Signature & Title Printed Name

_____ _____
NPI # Date