Pathways, Inc.

we put people first

Children and Family Treatment and Support Services (CFTSS)

Date of Referral: ____________________

Youth First/Last Name: ____ Gender: ______________

Youth Medicaid CIN (required): ________________________________ DOB: ______________________________

Consent provided by:
☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Youth (18 and older)

Consenter Name (Printed) ____

Consenter Signature (Preferred): ____ Date: ______________

Consenter Address: ____

Address Line 2 (county/city/state/zip): ____

Phone Number(s) – Mobile: ___________________________ Alternate Phone/Email: _______________________

Relationship to Youth: ________________________________ Preferred Time/Method of Contact? ___________

Is the youth currently enrolled in Medicaid or Medicaid Managed Care Plan? ☐ Yes ☐ No

If YES, which Plan?

☐ Fidelis ☐ Excellus/Blue Choice Option ☐ United/Optum ☐ MVP/Beacon/YourCare
☐ Univera ☐ Medicaid Fee-For-Svc ☐ Wellcare ☐ Other: __________
☐ Molina ☐ Capital District Health Plan Subscriber ID: ___________________________

Referral Source Name: ______________________________________ Title: ______________________________

Referral Source Organization: ____

Referral Address: ____

Referral Phone Number(s): ____________________________ Referral Email: ____________________________

Service(s) Requested:

☐ In Home Counseling (Other Licensed Practitioner) ☐ OLP Evaluation (Other Licensed Practitioner)

☐ Intensive Supports & Treatment (Community Psychiatric Supports & Treatment)

☐ Skill Building (Psychosocial Rehabilitation)

☐ Family Peer Support Services ☐ Youth Peer Support and Training (Available 1/1/20 for non-HCBS youth)

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School: ______________________________ Grade: __________

Pediatrician/Doctor: ______________________________ Provider Agency: ______________________

Is youth actively engaged in mental health counseling? ☐ Yes ☐ No

Mental Health Therapist: ______________________ Provider Agency: ______________________

Specialist/Additional Provider: ______________________ Provider Agency: ______________________

Symptoms of Concern

Check all symptoms that have impacted the youth over the past 60 days:

☐ Depression	☐ Anxiety	☐ Phobia	☐ Danger to self	☐ Danger to others
☐ Temper tantrums	☐ Sleep disturbances	☐Enuresis/Encopresis	☐ Physical complaints	☐ Alcohol use
☐ Developmental delays	☐ Sexually inappropriate	☐ Sexually aggressive	☐ Verbally aggressive	☐ Drug use
☐ Physically aggressive	☐ Eating disturbances	☐ Negative peer interactions	☐ Hyperactive	☐ Impulsive
☐ Self-injury	☐ Runaway	☐ Delinquent behavior	☐ Problematic social behavior	☐ Attention Deficits

Description of Symptoms or Cause of Concern: ____

____

____

Diagnoses

Mental Health Diagnoses (DSM-5 or ICD-10): ______________________________________

____

Physical Diagnoses: ____
(Physical diagnoses are an additional eligibility option for FPSS and YPST services)

Diagnosed by (Mental Health/Physical Health): ______________________________________

Diagnosis date (within past year): ____

Please attach any relevant documentation to support above with appropriately authorized release of information.

Thank you for your referral!

You can submit this form to Carolyn Little, Manager of Youth Service, via fax (607-937-3206), secure email (clittle@pathwaysforyou.org), or mail/in person (Administrative offices: 33 Denison Parkway W, Corning, NY 14830)

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******Medicaid eligibility required for all services******

Eligibility Criteria for In-Home Counseling (Other Licensed Practitioner):

Criteria 1 or 2 must be met: The child/youth is assessed by the Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:

1. Corrects or improve conditions that are found through an Early Periodic Screening and Diagnostic Testing (EPSDT): screening; OR
2. 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.

Eligibility Criteria for Intensive Supports & Treatment (Community Psychiatric Supports and Treatment):

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5 OR the child/youth is at risk of development of a behavioral health diagnosis; AND
2. The child/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, daily living skills, symptom management, coping strategies and effective functioning in the home, school, social or work environment.
3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND
4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License. (See chart below)

Eligibility Criteria for Skill Building (Psychosocial Rehabilitation)

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5; AND
2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to facilitate integration of the child/youth as participant of their community and family; AND
4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License. (see chart below)

Eligibility Criteria for Family Peer Support Services (FPSS)

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5; OR
2. The child/youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
4. The child/youth's family is available, receptive to and demonstrates need for improvement in the following areas such as but not limited to: Strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, strengthening overall supports in the child's environment; AND (see chart below)

Eligibility Criteria for Youth Peer Support and Training (YPST)

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5; OR
2. The child/youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
3. The youth requires involvement of a Youth Peer Advocate to implement the intervention(s) outlined in the treatment plan; AND
4. The youth demonstrates a need for improvement in the following areas such as but not limited to: enhancing youth's abilities to manage health needs; maintaining recovery, strengthening resiliency/self-advocacy; self-efficacy and empowerment, developing community resources and supports; transitioning into adulthood; AND
5. The youth is involved in the admission process and helps determine service goals; AND
6. The youth is available and receptive to receiving this service; AND (see chart below)

All services must be recommended by one of the following Licensed Practitioners of the Healing Arts:

Licensed Master Social Worker	Licensed Psychologist	Physician
Licensed Clinical Social Worker	Physician's Assistant	Registered Professional Nurse
Licensed Mental Health Counselor	Psychiatrist	Nurse Practitioner
Licensed Creative Arts Therapist	Licensed Psychoanalyst	Licensed Marriage and Family Therapist

Effective Date: ___________________

To Whom It May Concern:

In my clinical assessment ___________________________________(name of youth) meets Medical Necessity for Children and Family Treatment and Support Services (CFTSS) per information below:

Determination of Medical Necessity – Required for all services

☐ Yes or ☐ No (Check one). In my clinical assessment, this youth needs/would benefit from these services to (check all that apply- at least one): ☐ Likely to prevent onset of symptoms ☐ Likely to prevent worsening of symptoms

The service is needed to meet rehabilitative goals by restoring functioning level to facilitate integration of the youth as a participant of the community and family; and (check all that apply- at least one):

☐ Restore functioning level ☐ Rehabilitating functional level ☐ Facilitating participation in community, school, work, or home.

Required for Family Peer Support Services (FPSS): The youth's family is available, receptive to and demonstrates need for improvement in the following areas such as (check all that apply- at least one): ☐Strengthening the family unit ☐ Building skills within the family for the benefit of the child ☐ Promoting empowerment within the family ☐Strengthening the family overall supports

Required for Youth Peer Support and Training (YPST): ☐ Yes or ☐ No (Check one): The youth requires involvement of a YPA to implement the intervention(s) outlined in the treatment plan; AND the youth is involved in the admission process and goal creation AND the youth demonstrates a need for improvement in the following areas (check all that apply- at least one): ☐Managing health needs ☐Maintaining recovery ☐Strengthening resiliency/self-advocacy ☐Self-efficacy and empowerment ☐ Utilizing community resources ☐Transitioning into adulthood

List DSM-5 or ICD-10 diagnoses:

Diagnosis Code:	Diagnosis(es):

and/or

Behavioral/Mental Health/Substance Abuse Symptoms:

*******REQUIRED- Services needed:**

☐ In-Home Counseling (OLP) ☐ Evaluation (OLP) ☐ Intensive Services & Treatment (CPST) ☐ Skill Building (PSR)

☐ Family Peer Support Services ☐Youth Peer Support and Training (Available 1/1/20 for non-HCBS youth)

Clinician Signature (with credentials):____________________ Date:_______________

Clinician Name (with credentials, printed):_______________________________________NPI Number: ______________

License Number: _______________ Agency / Clinic Name (if applicable, printed): ________________________________

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