Collaborative For Children & Families

**The Collaborative for Children and Families Health Home (CCF)**

# REFERRAL FACESHEET

**INSTRUCTIONS**: Please complete this form for ALL referrals made to the CCF Health Home. Community Referrals must submit this form to referrals@ccfhh.org or fax it to: **646-459-3989.**

**BASIC DEMOGRAPHIC-***This form is to be used prior to adding the adding a new referral to MAPP or GSIHealth*

| TODAY'S DATE | |
|---|---|

| CHILD'S NAME, (***LAST, FIRST, MI,***) *(Include any alias, nicknames or other names the child may be known by)*: | DATE OF BIRTH: |
|---|---|

CHILD'S CURRENT ADDRESS*:*

| CITY: | ZIP: | COUNTY OF RESIDENCE: ☐NYC ☐WESTCHESTER ☐NASSAU ☐SUFFOLK |
|---|---|---|

| Gender: ☐ Male ☐ Female ☐ Transgender Male ■ Transgender Female ■ Not Known | LANGUAGE PREFERENCE OTHER THAN ENGLISH: |
|---|---|

**INSURANCE**

| MEDICAID/CIN #: | MCO PLAN NAME: (If any) **If copy of Medicaid card available please attach** |
|---|---|

**PERMISSION TO REFER:** *You must identify that consent to refer has been obtained and who has given consent to refer. Please note that this can be a verbal consent received.*

PLEASE INDICATE THE INDIVIDUAL FROM WHOM YOU HAVE OBTAINED CONSENT TO REFER A CHILD TO THE HEALTH HOME PROGRAM

☐Parent ☐ Guardian ☐ Legally authorized representative ☐ member/self/individual if 18 years or older ☐ member/self/individual is under 18, but is a parent or is pregnant or is married.

Date permission obtained:

**LEGAL GUARDIAN**

| MEDICAL CONSENTER'S NAME: | RELATIONSHIP TO CHILD: | | E-MAIL ADDRESS: | |
|---|---|---|---|---|
| MEDICAL CONSENTER ADDRESS: | CITY: | STATE: | ZIP CODE: | GUARDIAN's PHONE #s: H: C: |
| Is child in Foster Care? Yes ☐ NO ☐ Unknown ☐ | | | | |

**FAMIY/RESIDENTIAL INFORMATION**

IS ANY OTHER FAMILY MEMBER CURRENTLY ENROLLED IN ANOTHER HH OTHER THAN CCF? ☐ YES ☐ NO

| IF YES: FAMILY MEMBER NAME: | RELATIONSHIP TO CHILD: | HEALTH HOME NAME: | CARE MANAGEMENT AGENCY: |
|---|---|---|---|

**HEALTH HOME ELIGIBILITY CRITERIA (* Note:** *if documentation is available to support any of these conditions please attach)*

**ELIGIBILITY TYPE** ***(Check only one)***
***(if ICD10 code available please provide)***

☐ Two or More Chronic Conditions. List Conditions:
1.
2.

**OR one of the following single qualifying conditions**

☐ Serious Emotional Disturbance (SED)
List condition: ____**OR**
☐ complex trauma **OR**
☐ HIV/AIDS

**APPROPRIATENESS CRITERIA** ***(Check all that apply)***

☐ At risk for adverse event (death, disability, inpatient or nursing home 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
☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

**REFERRAL SOURCE:**

☐ Hospital ☐ MCO ☐ VFCA (NYC only) ☐ LDSS Rest of State ☐ Community Based Organization ☐ School ☐ Primary Care Physician
☐ Mental Health Provider ☐ Specialist ☐ Preventive Services Other:

| REFERRAL ORGANIZATION: | PERSON MAKING REFERRAL: |
|---|---|

PERSON MAKING REFERRAL CONTACT INFO:

PHONE: E-Mail:

**OPTIONAL** *(Please check any documents included):*

Lack of documentation will not impede the member's referral to the Health Home with the exception of referrals made under COMPLEX TRAUMA-see below

| ✓ | Document Type | 2 CHRONIC CONDITIONS | SED | HIV/AIDS | COMPLEX TRAUMA | DESCRIPTION |
|---|---|---|---|---|---|---|
| **REQUIRED DOCUMENTATION** | | | | | | |
| | Complex Trauma Pre Assessment | | | | ✓ | Complex Trauma Exposure Screen Form and Referral Cover Sheet- Completed by **non-licensed professional** or licensed professional. |
| **THIS DOCUMENTATION IS NOT REQUIRED TO PROCESS A REFERRAL. PLEASE ATTACH IF AVAILABLE.** | | | | | | |
| | Complex Trauma Post Assessment | | | | ✓ | ***Licensed behavioral health professionals***- CT Exposure Assessment Form, Functional Impairment Assessment, CT Eligibility Determination Form and other/additional background information or supporting materials* |
| | Psychosocial | ✓ | ✓ | ✓ | | Evaluation must be completed within the past **(6) months** of date of referral |
| | Psychiatric | | ✓ | | | Evaluation must be completed within the past **(6) months** of date of referral |
| | Medical/Physical | ✓ | | ✓ | | Evaluation must be completed within the past twelve **(12) months** of date of referral |
| | E.I Assessments | | | | | TBD |
| **CONSENTS** *as of October 24, 2016* | | | | | | |
| | Consent FAQs | ✓ | ✓ | ✓ | ✓ | Health Home Consent Frequently Asked Questions (FAQ) For Use with Children and Adolescents Under 18 Years of Age |
| | DOH-5201 | ✓ | ✓ | ✓ | ✓ | Information Sharing for children under 18 years of age |
| | DOH-5055 | ✓ | ✓ | ✓ | ✓ | Information Sharing and permission to enroll for youth and adults 18 years or older. |
| | DOH-5200 | ✓ | ✓ | ✓ | ✓ | Consent for Enrollment for use with Children and Adolescents under 18 Years of Age |
| | DOH 5203 | ✓ | ✓ | ✓ | ✓ | Health Home Consent Information Sharing Release of Educational Records |
| | DOH 5204 | ✓ | ✓ | ✓ | ✓ | Consent Withdrawal of Release of Educational Records |
| | DOH 5230 | ✓ | ✓ | ✓ | ✓ | Health Home Functional Assessment Consent |
| **FOR DEVELOPMENTAL CONDITIONS ONLY** | | | | | | |
| | Psychological/Education /Developmental Assessment | ✓ | | | | An evaluation must be completed as needed within the past twenty four **(24) months** of date of referral to validate chronic developmental conditions when appropriate. |

* **Definition of "Licensed Professional"**

Licensed Masters Social Worker, LMSW; Licensed Clinical Social Worker, LCSW, Psychologist, Psychiatrist, Licensed Nurse Practitioner, LNP, Licensed Marriage and Family Therapist, LMFT, Licensed Mental Health Counselor, LMHC, Psychiatric Nurse Practitioner.

***Note:*** The Health Home Care Manager and the Licensed Professional should not be the same person.

Please submit this form to Referrals@ccfhh.org

For assistnce with completing this form, please call 212-444-5437 or **Toll Free:** 1-888-913-4223