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