Date referral submitted:

Date referral complete:

## CARE MANAGEMENT REFERRAL FORM

## CHILD INFORMATION:

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| CHILD’S NAME (LAST, FIRST MI): | | | DATE OF BIRTH: | | GENDER:  Male Female  Other |
| MEDICAID CIN: | CHILD’S CURRENT ADDRESS (INCLUDE CITY, STATE, ZIP CODE): | | | | |
| CAREGIVER’S NAME: | PHONE NUMBER: | | | CONSENTER’S ADDRESS (if different from child’s) | |
| CHILD IS / HAS BEEN IN FOSTER CARE:  Current  Previous  None | |

1. CONSENT TO REFER:Consent to make this referral 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.

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| --- | --- | --- |
| CONSENTER’S NAME: | PHONE NUMBER: | CONSENTER’S ADDRESS (if different from child’s) |
| RELATIONSHIP TO YOUTH/CHILD:  Parent  Guardian Legally Authorized Representative  Youth 18 or over Youth (parent)  Youth (pregnant) Youth (married) | | |

1. **REFERRAL INFORMATION:**

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

1. **ELIGIBILITY:** Check Category child is being referred through

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| **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**  **Sickle Cell Disease** |

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

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| 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: |

1. **ADDITIONAL CRITERIA & INFORMATION:**

|  |  |
| --- | --- |
| Can referral source provide proof of eligibility? | Yes  No |
| Is the child currently in Foster Care? | Yes  No |
| Is the child/youth’s parent or guardian currently enrolled in the Health Home Program? | Yes  No |
| Is the child/youth current admitted to an inpatient facility? | Yes  No  If yes, name of facility:  Expected discharge Date: |

1. **OTHER INFORMATION RELATED TO THE YOUTH/FAMILY THAT MAY BE HELPFUL IN BEGINNING SERVICES:**

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|  |

**PLEASE SUBMIT ALL REFERRALS AND REFERRAL INQUIRES TO:**

**Email:** [ManagedCareReferrals@elmcrest.org](mailto:ManagedCareReferrals@elmcrest.org)

**Fax: 315-295-1888**

**960 Salt Springs Road, Syracuse New York 13224**

