elmcrest
Building on the promise of children and families.

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	☐Child Welfare/Child Protective Services
☐Physical Health Care Agency/Clinic Provider	☐Preventative Services
☐Substance Abuse Agency/Clinic/Provider	☐Family Court
☐Intellectual Disabilities Agency/Clinic/Provider	☐Juvenile Court/Corrections/Probation/Police
☐School/Educational Facility/Staff	☐Kinship Care
☐Early Intervention	☐Inpatient Facility, if yes, Name of facility: _______________________
☐Child's parent currently enrolled in the Health Home Program	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:** *(if ICD-10 code(s) are available please include them)*

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

***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 (i.e. male or female, easy going- strict):
Scheduling Needs/Preferences (i.e. not available on weekends, child returns from school at 2 pm etc):

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