CATHOLIC CHARITIES
HOPE for all seasons

Scan & Email to: carecoordination@ccwny.org
Call with questions: 716-364-3623

Encompass HEALTH HOME

CARE COORDINATION SERVICES REFERRAL

Please Note ALL **IDENTIFYING INFORMATION** *is required for proper processing of referral*

<table>
<tr><td rowspan="2">Individual's Name:</td><td colspan="2">Date of REFERRAL:</td></tr>
<tr><td>Date of Birth:</td><td>Sex: M or F</td></tr>
<tr><td rowspan="2">Current Address:</td><td colspan="2">County of Residence:</td></tr>
<tr><td colspan="2">PHONE #:</td></tr>
<tr><td>Medicaid/CIN#:
Managed Care Insurance:</td><td colspan="2">Other Insurance (Adults ONLY)</td></tr>
<tr><td colspan="3">Indicate Need for Interpreter services:</td></tr>
<tr><td colspan="3">(0-21) Is the youth in Foster Care? __ Yes __ No __ Unknown
If a child is currently in foster care, only the Local Dept of Social Services (LDSS) may complete the referral</td></tr>
<tr><td colspan="3">(0-21) Is the youth currently receiving Preventive Services? If YES, list:</td></tr>
<tr><td>Does the Individual currently receive Care Management Services? YES NO Unknown</td><td colspan="2">Current Care Management Agency:</td></tr>
<tr><td>Is the individual's parent/guardian enrolled in a Health Home/Care Management Agency? YES NO Unknown</td><td colspan="2">If YES - Parent's CIN/Medicaid #:</td></tr>
<tr><td colspan="3">Individual's Diagnoses (please indicate diagnoses & ICD diagnostic codes)
1.) ____________________ 2.) ____________________
3.) ____________________ 4.) ____________________</td></tr>
</table>

ELIGIBILITY INFORMATION (select most appropriate referral criteria)

__ **ONE or more Mental Health Conditions** – ***ADULTS ONLY***

__ **TWO or more Chronic Conditions** (mental, behavioral and/or physical)*(attach supporting documentation) (see full list of qualifying conditions at http://encompasshealthhome.org/resources)*

OR

__ **HIV/AIDS (***attach supporting documentation)*

OR

__ **Complex Trauma** *(attach supporting documentation)*

1) **Complex Trauma Exposure Screen** MUST be completed for referral to be processed
2) **Complex Trauma Assessment** may be attached if one has already been completed. The FULL Assessment must be completed prior to enrollment in the Health Home.

OR

__ **SED (Serious Emotional Disturbance)** or **SMI (Serious Mental Illness)** To qualify under SED/SMI, the individual must have a mental/behavioral diagnosis **AND** have experienced functional limitations due to the diagnosis over the past 12 months on a continuous or intermittent basis. **If the individual has a single SED diagnosis, a Health Home SED Verification form MUST be completed.**
To obtain the SED verification form please Visit www.ccwny.org > Care Coordination Services > Referral Forms, or call 716-364-3623

APPROPRIATENESS CRITERIA (reason Individual needs Care Coordination)

Select ALL that apply:

___ At risk for adverse event *(death, disability, inpatient or nursing home admission, mandated preventative services, or out of home placement)*

___ Has inadequate social/family/housing support, or serious disruptions in family relationships

___ Has inadequate connectivity with the 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 has cognition issues

___ Is concurrently eligible or enrolled, along with either their child or caregiver, in a health home

ADDITIONAL INFORMATION *(Please provide any additional information that may be helpful in appropriate assignment of the individual)*

REFERRER INFORMATION

Name & Credentials:	Phone:
Title/Role:	Email:
Organization:/Company:	Relationship to Individual:

CONSENT to REFER/Be Contacted by Care Coordination Services

Name of Consenter:	**Relationship to Individual:**
Phone Number:	**Other Phone:**

Signature of this section by the person providing consent to be referred indicates that the parent/guardian (for youth under the age of 18) OR individual (18+ years of age, OR pregnant, a parent, or married) gives consent to be referred for Care Coordination Services AND for the assigned Care Management Agency to contact the Referrer listed above for purposes of confirming the referred individual's eligibility, and to assist in making first contact/scheduling an enrollment appointment. Additional consents will be completed with the individual/family as applicable.

Who has provided consent for this referral to be made?

__ Parent __ Guardian __ Legally Authorized Representative

__ Individual who is (circle one): 18 years or older a Parent Pregnant Married

Signature of Consenter:	**Date of Consent:**