COORDINATED BEHAVIORAL CARE

Health Home Serving Children Referral/Eligibility form

To enroll in the HH program, applicants must be actively enrolled in Medicaid Fee for Service (FFS) or in Managed Medicaid (MM), have a qualifying condition(s), and benefit from Care Coordination services. Please complete this confidential form to confirm the member's eligibility.
If member's guardian is interested in connecting to a Health Home, refer to the Adult HH Referral/Eligibility Form available on our website.

Today's Date: [Date]				Care Management Agency:	
MEMBER INFORMATION					
Member's Name: [Last]	[First]	[Middle]	Date of Birth	Age:	Gender
Street Address:		City/State		Zip Code:	
Apartment/Unit#:	Home phone: [Phone]		Cell phone: [Phone]	Email address:	

☐Recent Family ☐Criminal Court Involvement Probation Officer Name and Number:

Current Living Situation: Language Preference other than English:

PCP INFORMATION

Physician Name/Health Center:	Address:	Phone Number:	Fax Number:

☐ Check only if Member is over 18, parent, pregnant, or married. Is Child in Foster Care? ☐Yes ☐ No (If yes, please fill in VFCA section)

MEDICAID /MANAGED CARE INFORMATION

Medicaid ID number: _____ ☐Ineligible ☐Eligible MCO: _____

PERMISSION TO REFER: You must identify that consent to refer has been obtained and who has given consent to refer. Please note that verbal consent is required.
PLEASE INDICATE THE INDIVIDUAL FROM WHOM YOU HAVE OBTAINED CONSENT TO REFER A CHILD TO THE HEALTH HOME PROGRAM

☐Parent ☐Legal 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:

REFERRAL SOURCE

☐Hospital ☐ MCO ☐Foster Care Agency ☐School ☐Primary Care Physician/Specialist ☐ Mental Health Provider ☐Other:_____

Referral Source Organization:	Referral Source Name/Title:	Referral Source Number:
Referral Source Email:		

PARENT/LEGAL GUARDIAN

Parent/Legal Guardian Name: [Last]	[First]	[Middle]	
Relationship to Child:	:_____		
Street Address:	City/State		Zip Code:
Apartment/Unit#:	Home phone no.: [Phone]	Cell phone no.: [Phone]	Email address:

VOLUNTEER FOSTER CARE AGENCY

Foster Care Agency:	Medical Consenter Name: [Last]	[First]	
Street Address:	City/State		Zip Code:
Title:	Home phone no.: [Phone]	Cell phone no.: [Phone]	Email address:

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 ☐ Sickle Cell Disease (SCD)
☐ 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

RESOURCES &

For CBC HHSC Consent or for a full listing CBC MCO Contracts LINKS www.cbcare.org More information contact 646-930-8851 or 866-899-0152

Additional Information:

Print Name of person completing form:_____ **Signature of person completing form:**_____