Pathways, Inc.
we put people first

## Children's Care Management Referral

Consent to make this referral must be obtained from the parent/guardian/legally authorized representative for children up until the age of 18. *For children/youth ages 18-21, or that are married, a parent, or pregnant may provide consent on their own behalf.* Who has provided you with consent to make this referral?

____ Parent ____ Guardian ____ Legally Authorized Representative

____ Youth who is (circle): 18 years or older A parent Pregnant Married

Consenter Name (Printed) _____

Consenter Signature (Preferred): _____ Date: _____

Consenter Information – Address: _____

Address Line 2 (county/city/state/zip): _____

Phone Number(s) – Mobile: _____ Alternate Phone: _____

Email: _____ Relationship to Youth: _____

Preferred Time/Method of Contact? _____

Is the Consenter currently enrolled in a Health Home? ____ Yes ____ No

If YES, Consenter's Medicaid CIN (if available): _____

Youth First/Last Name: _____ Assigned Gender (on IDs): _____

Youth Preferred Name: _____ Youth Preferred Pronouns (he/she/they/etc): _____

Youth Medicaid CIN (required): _____ DOB: _____

Is the Youth currently in foster care? ____ Yes ____ No

Is the Youth currently receiving Preventive or Care Management services? ____ Yes ____ No

Youth/Consenter's Preferred "Health Home" (the nationwide Health Home model provides an umbrella of coordinated care through a group of providers – it is not a place):

____ CHHUNY/Children's Health Home of Upstate New York ____ Encompass ____ No preference

Referral Source Name: _____ Title: _____

Referral Source Organization: _____

Referral Address: _____

Referral Phone Number(s): _____

Referral Email: _____

**Eligibility Criteria**

- ☐ **Two or more Chronic Conditions** (examples include: asthma, substance use disorder, diabetes, cerebral palsy, sickle cell anemia, cystic fibrosis, epilepsy, spina bifida, congenital heart problems, ADHD, mental health diagnoses, substance use disorder, developmental disorder)

*List Qualifying Chronic Conditions:* _____

**OR**

- ☐ **Serious Emotional Disturbance (SED): *single qualifying condition.*** *List SED diagnosis:* _____

SED is defined as a child or adolescent (under the age of 21) that has a mental health diagnosis in the most recent version of the Diagnostical and Statistical Manual (DSM) under one of the following categories: ADHD; Anxiety Disorders; Bipolar and Related Disorders; Depressive Disorders; Disruptive, Impulse-Control, and Conduct Disorders; Dissociative Disorders; Elimination Disorders; Feeding and Eating Disorders; Gender Dysphoria; Obsessive-Compulsive and Related Disorders; Medication Induced Movement Disorders; Paraphilic Disorders; Personality Disorders; Schizophrenia Spectrum and Other Psychotic Disorders; Sexual Dysfunctions; Sleep Wake Disorders; Somatic Symptom and Related Disorders; Trauma-and Stressor-Related Disorders; Tic Disorder **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); OR
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); OR
- Social relationships (e.g. establishing and maintaining friendship; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); OR
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgement and value systems; decision-making ability; OR
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)

**OR**

- ☐ **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.**

Definition of Complex Trauma:

a. The term complex trauma incorporates at least:
- Infants/children/or adolescents' exposure multiple traumatic events, often of an invasive, interpersonal nature, and
- The wide-ranging, long-term impact of this exposure

b. The nature of the traumatic events:
- Often is severe and pervasive, such as abuse or profound neglect;
- Usually begins early in life;
- Can be disruptive of the child's development and the formation of a health sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
- Often occur in the context of the child's relationship with a caregiver; and
- Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for health social-emotional functioning.

c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability

d. Wide-ranging, long-term adverse effects can include impairments in physiological responses and related neurodevelopment, emotional responses, cognitive processes including the ability to think, learn, and concentrate, impulse control and other self-regulating behavior, self-image, and relationships with others.

**OR**

- ☐ **HIV/AIDS: *single qualifying condition***

**Risk Factors**

*Please check applicable risk factor(s) and provide a brief explanation.*

- ☐ At risk for adverse event (e.g. 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

- ☐ Youth is placed out-of-home, was recently (within 6 months) out-of-home or referred to out-of-home placement, is at risk of out-of-home placement, or within 6 months has been seen at the Emergency Room or CPEP for behavioral health needs, and would benefit from assessment to Children's Waiver / HCBS.

Explanation of above / Other helpful information regarding this referral: _____

_____

_____

_____

_____

_____

***Please attach any relevant documentation to support above with appropriately authorized release of information.***

Thank you for your referral!

*You can submit this form to Angie Longwell, Manager of Care Coordination, via fax (607-937-3206), secure email (alongwell@pathwaysforyou.org), or mail/in person (Administrative offices: 33 Denison Parkway W, Corning, NY 14830).*

*Please call Angie at 607-937-4520 with any questions!*