Pathways, Inc.
we put people first

Children and Family Treatment and Support Services

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 Medicaid or Medicaid Managed Care Plan? ☐ Yes ☐ No

If YES, which Plan?

☐ Fidelis ☐ Excellus ☐ United/Optum ☐ MVP/Beacon
☐ Univera ☐ Molina ☐ Wellcare ☐ Other: _____
☐ Medicaid Fee-For-Svc

Youth First/Last Name: _____ Gender: _____

Youth Medicaid CIN (required): _____ DOB: _____

Referral Source Name: _____ Title: _____
Referral Source Organization: _____

Referral Address: _____

Referral Phone Number(s): _____

Referral Email: _____

Service(s) Requested:

☐ In Home Counseling ☐ Intensive Supports & Treatment ☐ Skill Building

Symptoms of Concern

Check all symptoms that have impacted the youth over the past 60 days:

☐ Depression	☐ Anxiety	☐ Phobia	☐ Danger to self	☐ Danger to others
☐ Temper tantrums	☐ Sleep disturbances	☐Enuresis/Encopresis	☐ Physical complaints	☐ Alcohol use
☐ Developmental delays	☐ Sexually inappropriate	☐ Sexually aggressive	☐ Verbally aggressive	☐ Drug use
☐ Physically aggressive	☐ Eating disturbances	☐ Negative peer interactions	☐ Hyperactive	☐ Impulsive
☐ Self-injury	☐ Runaway	☐ Delinquent behavior	☐ Problematic social behavior	☐ Attention Deficits

Other Symptoms

Description of Symptoms or Cause of Concern: _____

_____

_____

_____

_____

Diagnoses

Mental Health Diagnoses (DSM-5 or ICD-10): _____

_____

Diagnosed by: _____

Diagnosis date: _____

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 Carolyn Little, Manager of Youth Service, via fax (607-937-3206), secure email (clittle@pathwaysforyou.org), or mail/in person (Administrative offices: 33 Denison Parkway W, Corning, NY 14830)

Eligibility Criteria for In-Home Counseling (Other Licensed Practitioner):

Enrollment to In-Home Counseling

Criteria 1 or 2 must be met:

The child/youth is being assessed by the Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:

1. Corrects or improve conditions that are found through an Early Periodic Screening and Diagnostic Testing (EPSDT): screening; OR
2. Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

Eligibility Criteria for Intensive Supports & Treatment (Community Psychiatric Supports and Treatment):

Enrollment to Intensive Supports & Treatment

All criteria must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5 OR the child/youth is at risk of development of a behavioral health diagnosis; AND
2. The child/youth is expected to achieve skill restoration in one of the following areas:

a. participation in community activities and/or positive peer support networks.	b. personal relationships;	c. personal safety and/or self-regulation
d. independence/productivity;	e. daily living skills	f. symptom management

g. coping strategies and effective functioning in the home, school, social or work environment

AND

3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms,

AND

4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License. (See chart below)

Eligibility Criteria for Skill Building (Psychosocial Rehabilitation)

Enrollment to Skill Building

All criteria must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5; AND

2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND

3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to facilitate integration of the child/youth as participant of their community and family AND

4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License. (see chart below)

List of Licensed Practitioners of the Healing Arts:

- Licensed Master Social Worker
- Licensed Clinical Social Worker
- Licensed Mental Health Counselor
- Licensed Creative Arts Therapist
- Licensed Marriage and Family Therapist
- Licensed Psychoanalyst
- Licensed Psychologist
- Physician's Assistant
- Psychiatrist
- Physician
- Registered Professional Nurse or
- Nurse Practitioner