OCFS-8000 (1/2011)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REFERRAL FORM

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME (*LAST, FIRST, MI,):*		
DATE OF BIRTH:	SEX: ☐ Male ☐ Female	MEDICAID CIN #:

B2H WAIVER TYPE *(Check one only)*	**REFERRAL TYPE *(Check one only)***
☐ B2H Serious Emotional Disturbance (SED) Waiver	☐ Initial Referral
☐ B2H Developmental Disabilities (DD) Waiver	☐ Subsequent Referral: completed if child name is on Wait List
☐ B2H Medically Fragile (MedF) Waiver	

A list of Health Care Integration Agencies was provided to the child/medical consenter. The child/medical consenter has selected the following agency:

HEALTH CARE INTEGRATION AGENCY NAME:			PHONE #:
Pathways, Inc.			607-937-4519
HEALTH CARE INTEGRATION AGENCY ADDRESS:	CITY:	STATE:	ZIP CODE:
33 Denison Parkway West	Corning	NY	14830
HEALTH CARE INTEGRATION AGENCY STAFF CONTACT NAME:			
Cynthia Gee, LMHC, Program Director			

The _____ has determined that the child
LOCAL DEPARTMENT OF SOCIAL SERVICES (LDSS) OR DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY)

identified above would benefit from the services offered by the B2H Medicaid Waiver Program. The child is Medicaid eligible. For a child in LDSS custody, we have assigned a role to their CONNECTIONS Family Services Stage.

To assist in your assessment of the child's suitability for the B2H Medicaid Waiver Program, we have included the following items:

- Authorization for Release of Information form(s), (OCFS-8001)
- B2H Medicaid Waiver Program Qualifying Diagnosis(es) and supporting documentation.
- **For a Subsequent Referral, all information from Initial Referral and Initial Application is included.**

MEDICAL CONSENTER NAME:		RELATIONSHIP TO CHILD:		
MEDICAL CONSENTER ADDRESS:	CITY:	STATE:	ZIP CODE:	PHONE #:

☒ **LOCAL DEPARTMENT OF SOCIAL SERVICES OR** ☐ **DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY) CONTACT INFO *(Check One)***

CONTACT'S NAME:	CONTACT'S SIGNATURE:	DATE:
	X	
CONTACT'S TITLE:		PHONE #:

CONTACT'S ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE:

Original – Health Care Integration Agency; **Copy of 8000 Form Only –** Child/Medical Consenter, Caregiver, Case Planning Agency, OCFS Quality Management Specialist; **Copy of 8000 Form and Supporting Documentation -** Local Department of Social Services or Division of Juvenile Justice and Opportunities for Youth