Children and Family Treatment and Support Services (CFTSS)

Date of Referral: _______________

Youth First/Last Name: ____________________ Birth Gender: __________

Gender Identity/Preferred Pronouns: ____________________

Youth Medicaid CIN (required): ____________________ DOB: ____________________

Consent provided by:
☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Youth (18 and older)

Consenter Name (Printed) ____________________

Consenter Signature (Preferred): ____________________ Date: ______________

Consenter 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 youth currently enrolled in Medicaid or Medicaid Managed Care Plan? ☐ Yes ☐ No

If YES, which Plan?

☐ Fidelis
☐ Univera
☐ Beacon
☐ Molina
☐ Excellus/Blue Choice Option
☐ Medicaid Fee-For-Svc
☐ YourCare
☐ Capital District Physicians' Health Plan
☐ United/Optum
☐ Wellcare
☐ MVP
☐ Other: __________
☐ Subscriber ID: ____________________

Referral Source Name: ____________________ Title: ____________________

Referral Source Organization: ____________________

Referral Address: ____________________

Referral Phone Number(s): ____________________ Referral Email: ____________________

Service(s) Requested:

☐ In Home Counseling (Other Licensed Practitioner) ☐ OLP Evaluation (Other Licensed Practitioner)

☐ Intensive Supports & Treatment (Community Psychiatric Supports & Treatment)

☐ Skill Building (Psychosocial Rehabilitation)

Pathways, Inc. Staff Only: Date Referral Received: _______________ Date Family Contacted: ______________

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School: ____ Grade: _________

Pediatrician/Doctor: ________________________________ Provider Agency: __________________________

Is youth actively engaged in mental health counseling? ☐ Yes ☐ No

Mental Health Therapist: ________________________________ Provider Agency: __________________________

Specialist/Additional Provider: ____________________________ Provider Agency: __________________________

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	☐ Attention Deficits	☐ Physical complaints	☐ Stealing/theft
☐ Developmental delays	☐ Sexually inappropriate	☐ Alcohol/Drug use	☐ Verbally aggressive	☐ Bullying/Victim of bullying
☐ Physically aggressive	☐ Eating disturbances	☐ Negative peer interactions	☐ Hyperactive/ Impulsive	☐ Adverse experiences/Trauma
☐ Self-injury	☐ Runaway/leaving without permission	☐ Involvement with legal system	☐ Problematic social behavior	☐Human trafficking/Exploitation
☐ Fire-Setting	☐ Fire Play	☐ Suicidal Ideation	☐ Suicidal behavior, including attempt(s)	☐ Sexually harmful or coercive behavior

Description of Symptoms or Cause of Concern:____

____

____

Diagnoses

Mental Health/Substance Abuse Diagnoses (DSM 5 or ICD-10):____

____

Diagnosed by: ____

Diagnosis date (within past year): ____

Please forward any additional clinical, educational, medical, or pertinent legal information as part of the referral/evaluation process (i.e. psychological or psychiatric reports/assessments, treatment plans, IEP's, school reports), 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)

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******Medicaid eligibility required for all services******

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

Criteria 1 or 2 must be met: The child/youth is 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):

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: participation in community activities and/or positive peer support networks, personal relationships, personal safety and/or self-regulation, daily living skills, symptom management, coping strategies and effective functioning in the home, school, social or work environment.
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)

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)

All services must be recommended by one of the following Licensed Practitioners of the Healing Arts:

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

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