Pathways, Inc.
we put people first

Children and Family Treatment and Support Services (CFTSS)

Date of Referral: _____

Youth First/Last Name: _____ Gender: _____

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 ☐ Excellus/Blue Choice Option ☐ United/Optum ☐ MVP/Beacon/YourCare
☐ Univera ☐ Medicaid Fee-For-Svc ☐ Wellcare ☐ Other: _____
☐ Molina ☐ Capital District Health Plan 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)

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	☐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

Description of Symptoms or Cause of Concern:_____

_____

_____

_____

Diagnoses

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

_____

_____

Diagnosed by: _____

Diagnosis date (within past year): _____

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)

******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