Children and Youth Evaluation Service
Your Connection to Home and Community-Based Services

Home and Community Based Services (HCBS) Referral Form

PO Box 5008
New York, NY 10275

Complete this form when referring a child/youth to C-YES for HCBS eligibility determination and HCBS coordination services.

Check the following are included with this referral:

- ❑ This completed and signed Referral Form
- ❑ Most recent information related to assessments, clinical, treatment and service information, as available.
- ❑ If the referent is other than the child, parent, legal guardian, caregiver or legally authorized representative, **a signed HIPAA compliant consent form** indicating the child or their legally authorized representative's approval to share their protected health, mental health and/or substance use information with C-YES.

What is the child's/youth's annual HCBS eligibility/Level of Care (LOC) reassessment date? (If applicable)

____ ____ /____ ____ / ____ ____ ____ ____
M M D D Y Y Y Y

PART 1 Child or Youth Demographic Information

This Part must be completed.
Fill in the child or youth's personal information. Be sure to give the child or youth's:

- Complete name and demographic information
- Medicaid Client Identification Number (CIN), if known
- Social Security Number (SSN), if known
- Primary language or communication method
- Current living arrangement
- Insurance type and, if private insurance, the insurance name and policy number, if known

1. Child or youth
   first name: _____ MI: ____ Last name:_____

2. Date of Birth: ____ ____ /____ ____ / ____ ____ ____ ____
   M M D D Y Y Y Y

***Part 1** continued on the next page ⇨

If you have questions about this form, call C-YES at
1-833-333-CYES (1-833-333-2937) TTY: 1-888-329-1541
Monday to Friday, from 8:30 am to 5:30 pm
Saturday, from 9:00 am to 12:00 pm

CYES-HCBS-RFW-E-0419

Part 1 *(continued)*

3. Gender: ❑ Male ❑ Female ❑ Other Gender expression: _____

4. Medicaid Client Identification Number (CIN) (if applicable): ___ ___ ___ ___ ___ ___ ___ ___

5. Primary language spoken and understood by child or youth: _____

6. Social Security Number (SSN): ___ ___ ___ - ___ ___ -___ ___ ___ ___

7. Current or primary address:

_____ _____

City County

_____ ___ ___ ___ ___ ___

State ZIP Code

8. Please check the one where the child or youth lives now:
   - ❑ Parent or legal guardian's home
   - ❑ Relative's home
   - ❑ Foster care
   - ❑ Out-of-home placement such as institution, hospital, nursing home or rehabilitation facility
     Describe: _____
   - ❑ Other: _____

9. Insurance type
   - ❑ No Medicaid
   - ❑ Medicaid: ___ Regular Medicaid (Fee for Service) or ___ Medicaid Managed Care Plan
   - ❑ Third party or private insurance

     Plan name: _____

     ID or Policy number: _____

PART 2 Parent, Legal Guardian, Caregiver or Legally Authorized Representative Contact Information

This Part must be completed. *The parent, legal guardian, caregiver or legally authorized representative must fill in this information for the child/youth who are under 18 years old, and are not pregnant, a parent and/or married. Be sure to:*

- Write your complete name, address and contact information
- If listing more than two contacts, write their names and contact information on a new page and attach it to this *Referral Form*

Part 2 *continued on the next page* ⇨

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***Part 2** (continued)*

- Complete all information below to allow communication with primary contacts
- Show the relationship with the child or youth, including whether the person is a primary contact, parent, legal guardian, caregiver or legally authorized representative. Check all that apply.
- Give the contact's primary language
- Please make every effort to complete the below information

CONTACT PERSON # 1:

Name:

First: _____ MI: _____ Last: _____

Are you the primary contact? ❑ Yes ❑ No

Check one: ❑ Parent ❑ Legal guardian ❑ Caregiver ❑ Legally authorized representative

Current or primary address: _____

City: _____ State: _____ ZIP Code: ___ ___ ___ ___ ___

Primary language: _____ Email address: _____

Home number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Work number: (___ ___ ___) ___ ___ ___ - ___ ___ ___

Cell number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Can we send you text messages? ❑ Yes ❑ No

CONTACT PERSON # 2:

Name:

First: _____ MI: _____ Last: _____

Are you the primary contact? ❑ Yes ❑ No

Check one: ❑ Parent ❑ Legal guardian ❑ Caregiver ❑ Legally authorized representative

Current or primary address: _____

City: _____ State: _____ ZIP Code: ___ ___ ___ ___ ___

Primary language: _____ Email address: _____

Home number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Work number: (___ ___ ___) ___ ___ ___ - ___ ___ ___

Cell number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Can we send you text messages? ❑ Yes ❑ No

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(Continued)

PART 3 Referent Information

This Part must be completed. *The person or organization submitting the referral must fill in this part. Be sure to:*

- Identify the source of this referral
- Give complete name, title, address and contact information
- Give the Health Commerce System identification number (HCS), if applicable

Referrer:

- ❑ Community provider
- ❑ Treating professional
- ❑ Family member
- ❑ Other (Explain): _____

Name of person making the referral:

First: _____ MI: _____ Last: _____

Organization name (if applies): _____

Address: _____

City:_____ State:_____ ZIP Code:_____

Phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

HCS User ID: _____ Email address: _____

PART 4 Based on your knowledge of the child or youth, check *all* services you recommend to help keep the child or youth in their home, school, and community.

Complete this Part if available. *Please be sure to check all recommended services that would help keep the child or youth in their home, school, and community.*

- ❑ Community Habilitation
- ❑ Community Self-Advocacy Training and Support
- ❑ Day Habilitation
- ❑ Prevocational Services
- ❑ Supported Employment
- ❑ Youth Peer Support and Training
- ❑ Crisis Intervention
- ❑ Respite (Planned or Crisis)
- ❑ Caregiver/Family Support and Services
- ❑ Family Peer Support Services
- ❑ Environmental Modifications
- ❑ Vehicle Modifications
- ❑ Adaptive and Assistive Equipment
- ❑ Palliative Care
- ❑ Non-Medical Transportation

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(Continued)

PART 5 Health and Behavioral Health History (past 6 months)

Complete this Part if available. *The child or youth's PCP, specialist, behavioral health provider, or the person who is referring the child/youth can fill in this part. Check* ***all*** *health services used in the past* ***6 months.***

- ❑ Outpatient mental health treatment
- ❑ Outpatient substance use treatment
- ❑ Emergency room visit for psychiatric condition
- ❑ Medical and/or psychiatric hospitalization
- ❑ Emergency room visit for health condition
- ❑ Past residential or out-of-home placement (Describe): _____

_____

_____

PART 6 Current Health and Behavioral Health

Complete this Part if available. *The child or youth's PCP, specialist, behavioral health provider, or the person who is referring the child/youth can fill in this part.*

Check all current health and behavioral health statuses that apply.

- ❑ Medically fragile
- ❑ Serious Emotional Disturbance Determination
- ❑ Developmentally disabled and in foster care
- ❑ Developmentally disabled and medically fragile
- ❑ Complex trauma; emotional, physical
- ❑ Chronic conditions (one or more)
  Names:
  _____
  _____
  _____
  _____

Please provide the current Diagnostic and Statistical Manual of Mental Disorders (DSM) – V diagnosis. Only fill in this part if within scope of practice or with documents from appropriate provider. Give the current health and/or behavioral health provider's name and telephone number in ***Primary Provider's Information****.*

DSM – V _____

_____

_____

Primary Provider's Information:

Name:_____

Contact number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Name:_____

Contact number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

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QUESTIONS? 5

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(Continued)

PART 7 Signature of Referent

This Part must be completed. *The person referring the child or youth must fill in this part. If the referent is the parent, legal guardian, caregiver or legally authorized representative, please sign below.*

Referent must fill in this part:

By signing this form, I am submitting a HCBS referral for the child or youth listed in Part 1.

Name of referent (print): _____

Signature: _____ Date: ___ ___ /___ ___ /___ ___ ___ ___
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Part 8 DOES NOT replace a **signed HIPAA compliant consent form** when the referent is other than the child, parent, legal guardian, caregiver or legally authorized representative.

PART 8 Authorization for Referral and Release of Information: Written release is required when sharing personal health information (PHI) during a referral

This Part must be completed *only when the referent is the child/youth, parent, legal guardian, caregiver or legally authorized representative.*

- ***Self-consenting Children and Youth must fill in this information***
  - ***Children/youth who are 18 years old or older, or***
  - ***Children/youth who are under 18 years of age who are pregnant, a parent and/or married***
- ***The parent, legal guardian, caregiver or legally authorized representative must fill in this information for the child/youth who are under 18 years old, and are not pregnant, a parent and/or married***

By signing below, I am giving written consent to share_____'s personal health information (PHI) during a referral.
(Child or youth's name)

Written consent and release:

Name of person giving the written consent:

First: _____ MI: _____ Last: _____

Relationship to child or youth: _____

Signature: _____

Date of written approval: ___ ___ /___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

QUESTIONS?

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