



# 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)

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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## 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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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**Part 1 continued on the next page** ➡

## QUESTIONS? 1

**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

**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 ➡

**QUESTIONS?**

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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.

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

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### QUESTIONS?

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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.

- |   |   |
|---|---|
| <input type="checkbox"/> Medically fragile                              | <input type="checkbox"/> Chronic conditions (one or more) |
| <input type="checkbox"/> Serious Emotional Disturbance Determination    | Names: _____  |
| <input type="checkbox"/> Developmentally disabled and in foster care    | _____   |
| <input type="checkbox"/> Developmentally disabled and medically fragile | _____   |
| <input type="checkbox"/> Complex trauma; emotional, physical            | _____   |

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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(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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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