



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 ➡

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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