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

Home and Community Based Services (HCBS) Referral Form For Transitioning Waiver Child/Youth

For Use by Care Management Agencies Only

Complete this form when referring a child/youth to C-YES for HCBS coordination services. Missing information may delay referral.

Check the following are included with this referral:

- ❑ This completed and signed Referral Form
- ❑ **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.
- ❑ A completed DOH-5059 Health Homes Opt-Out Form
- ❑ An updated Plan of Care (POC) for the child/youth being referred to C-YES, identifying involved providers and services **cross walked** to new service names

  OR

- ❑ No POC available
- ❑ Historic assessments, clinical, treatment and service information, as available.

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

___ ___ /___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

PART 1 Child or Youth Demographic Information

Fill in the child or youth's personal information.

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

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

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): ___ ___ ___ - ___ ___ -___ ___ ___ ___

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

QUESTIONS?

If you have questions about this form, call CYES 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)*

7. Current or primary address:

_____ _____
City County

_____ ____ ____ ____ ____ ____
State ZIP Code

8. Alternate current address:

_____ _____
City County

_____ ____ ____ ____ ____ ____
State ZIP Code

9. 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: _____

10. Insurance type
    - ❑ 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

The parent, legal guardian, caregiver or legally authorized representative must fill in this part.

CONTACT PERSON #1:

Name:

First: _____ MI: _____ Last: _____

Are you the primary contact? ❑ Yes ❑ No

***Part 2** continued on the next page ⇨*

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***Part 2** (continued)*

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

PART 3 Referent Information

The person or organization submitting the referral must fill in this part.

Referrer:

❑ Community provider ❑ Treating professional ❑ Family member

❑ Other (Explain): _____

***Part 3** continued on the next page ⇨

QUESTIONS? 3

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***Part 3** (continued)*

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 Signature of Referent

The person referring the child or youth 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 5 Authorization for Referral: Written consent is required and must be signed and submitted with this Referral Form when sharing personal health information (PHI) during a referral.

The parent, legal guardian, caregiver or legally authorized representative must fill in this part.

By signing below I am giving written approval to refer _____
(Child or youth's name)
to the Children and Youth Evaluation Service.

Written approval:

Name of person giving the written consent:

First: _____ MI: _____ Last: _____

Relationship to child or youth: _____

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

QUESTIONS?

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