**Community Referral**

 **Children and Families Treatment Support Services (CFTSS)**

**& Home and Community Based Services (HCBS)**

**Program Descriptions:**

*Children and Family Treatment Support Services (CFTSS)[[1]](#endnote-1)*

CFTSS are an array of clinical treatment and rehabilitative services intended to support and stabilize a child in their family and community. Services can be delivered in a child’s natural environment including, home, school or other community setting. Children must be on Medicaid and the services must be recommended by a licensed health practitioner. If a child is not currently being treated, they can be referred for an evaluation to see if they may be eligible for CFTSS services. [[2]](#footnote-1)

*Home and Community Based Services (HCBS)[[3]](#footnote-2)*

HCBS are designed to offer support and services to children who have significant mental health needs, medical issues or a developmental disability. They are meant to help a youth function in their home and community and prevent hospitalization or other institutional levels of care. Children must be on Medicaid and undergo a screening and assessment process to obtain eligibility. Once eligible, children and their families chose from an array of service options that best meet their individual needs.

**How to Make a Referral:**

1. Complete the attached Community Referral Application Form, including as much detail as possible to allow St. Catherine’s Center for Children to contact the parents/caregivers and to verify Medicaid eligibility.

2. Attach supporting documentation of diagnosis (if available).

3. Referrals for HCBS services **must be** accompanied by the ***“Level of Care Eligibility Determination Letter”***

4. Send the completed application and consent via secure e-mail or fax, or mail to:

**St. Catherine’s Center for Children**

**Community Based Treatment and Support Services Program**

**40 North Main Avenue, Albany NY 12203**

**intake@st-cath.org**

**Attention: Alyssa Barkley**

**Fax: 518-464-6827**

**Questions? Call 518-453-6783**

**Be sure to include all pages in your submission!**

|  |
| --- |
| **Referral for Children and Family Treatment Support Services (CFTSS)** **& Home and Community Based Services (HCBS)**  |
| **CHILD INFORMATION** |
| **Date of Referral:** | **Date of Birth:** | **Gender Identity/Gender at Birth:**  |
| **Child’s Name (Last, First, MI.) :** |
| **Race/Ethnicity:** | **School and Grade:** | **Education (Circle One):****IEP 504 Regular Ed.** |
| **Address:**  | **Telephone:** |
| **Diagnosis and ICD 10 Code: (if applicable)** | **Allergies:** |
| **Is the child seeing a mental health provider? If so, with whom and where?:** | **Primary Care Physician:** |
| **Current Medications:** |
| **INSURANCE** |
| **Medicaid CIN #:** | **Managed Care Plan:** |
| **PARENT/CARE GIVER/LEGAL GUARDIAN**  |
| **Parent/Guardian’s Name (Last, First, MI.)** |
| **Address:** | **Phone:** |
| **REFERRAL SOURCE** |
| **Name: CEO-**  | **Organization and Address:** |  |
| **Phone:** | **License No: (if applicable)** |
|  **REFFERED SERVICES *(please check off the requested services)*** |
| **CFTSS Services*** **OLP Evaluation or Counseling**
* **Psycho-Social Rehabilitation**
* **Community Psychiatric Support Services**
* **Family Peer Support Services**

**HCBS Services** * **Planned Respite ( Day or Overnight )**
* **Pre-Vocational Training**
* **Care Giver/Family Support Services**
* **Community Self Advocacy Training and Support**
 |
| **STATEMENT OF NEED** (Provide a brief explanation of the child’s current behavioral health diagnosis or current conditions, their corresponding symptoms or functional impairments, and how the recommended services will improve their health and well-being) |
|  |

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| --- |
| **CONSENT TO REFER** |
| VERBAL CONSENT TO MAKE THIS REFERRAL MUST BE OBTAINED FROM THE PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE FOR CHILDREN UP UNTIL THE AGE OF 18. FOR CHILDREN/YOUTH AGES 18-21, OR THAT ARE MARRIED, A PARENT OR PREGNANT MAY CONSENT ON THEIR OWN BEHALF. Who has provided you with consent to make this referral to St. Catherine’s?  |
| * **Parent**
 | * **Guardian**
 | * **Legally Authorized Representative**
 | * **Child/Youth**

(18 yrs. old, Parent, Pregnant or Married) |

**AUTHORIZATION/CONSENT FOR DISCLOSURE OF INFORMATION**

Use this form to get New York State consents of HIPPA authorizations (The Sharing Clinical Information Table describes when Mental Hygiene Law consent or HIPPA authorization is needed).

**Part I – Client Information:**

 / /

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last Name |  | First Name: |  | MI: |  | Date of Birth |

Address:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Phone Number: |  |
|  |  | Cell Phone: |  |

**Part II – Releasing Or Obtaining Information:**

By signing this form, the client named in Part 1 above, authorizes the following organization:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CEO- Rensselaer County Head Start |  | To Release □ | Or Obtain □ | Information. |

Describe the information to be used or disclosed, including date(s) of service, types of service provided, etc.:

|  |  |  |
| --- | --- | --- |
| Date(s) of Service: |  |  |
| □ Psychological Evaluations/Assessments | □ CANS | □ FASP’s |
| □ Medical Assessments/Diagnostic Reports | □ Documentation Eligibility | □ School Records |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ IHP | □ DSP |

**Note:** The following must be completed by health care providers. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation for using or disclosing the health or clinical information described above?

□ No □ Yes

**Part III – Signature and Date:**

Part III must be signed by the client or his/her personal representative and a copy of the signed form provided to the client or representative.

1. I may revoke this authorization, in writing, at any time by notifying the person or entity I have authorized to use or disclose information as listed above.
2. I understand that a revocation is not effective against actions taken by the person or entity named above before they received such revocation and to the extent that they have relied upon this authorization.
3. I understand that if the person or entity authorized to receive my health and clinical information is not a health care provider or health plan, the released information may be re-disclosed and may no longer be disclosed by federal privacy regulations.
4. I may refuse to sign this form and my refusal to sign will not affect my ability to obtain treatment or payments except in some situations when such information is needed for payment and enrollment.
5. I may, in accordance with St. Catherine’s Center for Children Privacy Policy, inspect or copy any information used or disclosed under this authorization upon written request.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of Individual or Representative |  |  | Date: |  / / |
| Print Name of Individual or Representative |  |  |  |  |
| Representative’s Relationship to Individual |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Witness Signature |  | Date: |  / / |
| Print Name of Witness |  |  |  |

**Note**: This authorization expires one year from signed date above; this form may not be pre-dated or pre-signed; this form **DOES NOT** replace the HIV Consent Form (**See HIV Consent Form**).

1. [↑](#endnote-ref-1)
2. For a complete description of the CFTSS Services, and the criteria for Medical Necessity please reference the following NYS-DOH Guidance Document:

https://www.health.ny.gov/health\_care/medicaid/redesign/behavioral\_health/children/docs/updated\_spa\_manual.pdf [↑](#footnote-ref-1)
3. For a complete description of the HCBS program, please reference the following NYS-DOH Guidance Document: https://www.health.ny.gov/health\_care/medicaid/redesign/behavioral\_health/children/docs/hcbs\_manual.pdf [↑](#footnote-ref-2)