ST. CATHERINE'S CENTER FOR CHILDREN
40 North Main Avenue, Albany, NY 12203 • Phone: 518-453-6700 • Fax: 518-453-6712 • www.st-cath.org

Referral for
Children and Family Treatment & Support Services (CFTSS)

Children and Family Treatment & Support Services (CFTSS)[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 settings. Children must be enrolled in 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.

How to Make a Referral:

1. Complete the attached Referral 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. Send the completed referral to the CFTSS Program Coordinator Anna Cherubin, at the information listed below:

St. Catherine's Center for Children
Children and Family Treatment & Support Services Program
40 North Main Avenue, Albany NY 12203
acherubin@st-cath.org
Fax: 518-453-6699
Questions? Call 518-542-2823
Be sure to include all pages in your submission.

[1] 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

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CHILD INFORMATION

Date of Referral:	Date of Birth:	Gender Identity/Sex 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/CAREGIVER/LEGAL GUARDIAN

Parent/Guardian's Name (Last, First, MI.)	
Address:	Phone:

REFERRAL SOURCE

Name:	Organization and Address:
Phone:	License No: (if applicable)

REFERRED SERVICES **(Services other than OLP must be accompanied by an LPHA recommendation)**

__**Other Licensed Practitioner Services** (Mental Health Services)
__**Community Psychiatric Support Services** (Supportive Counseling)
__ **Psycho-Social Rehabilitation** (Skill Building)

Reason for Referral (**Required**, please be specific and attach additional sheets as necessary. Symptoms and/or behaviors that have you concerned.)

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)
x _____	x _____	x _____	x _____

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AUTHORIZATION/CONSENT FOR DISCLOSURE OF INFORMATION

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

Part I – Client Information:

Last Name	First Name:	MI:	/ / Date of Birth

Address: _____

Phone Number: _____

Email Address: _____

Part II – Releasing Or Obtaining Information:

By signing this form, the client named in Part 1 above authorizes the following organization:
Name of Organization_____
Phone number of organization_____

To (circle one or both) **RELEASE** or **OBTAIN** information relevant to this individual's treatment.

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

- ☐ Psychological Evaluations/Assessments
- ☐ FASPs
- ☐ Medical Assessments/Diagnostic Reports
- ☐ Eligibility Documentation
- ☐ School Records
- ☐ Other: _____

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 healthcare provider or health plan, the released information may be re-disclosed and may no longer be protected 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 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's 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 the 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**).