Children and Family Treatment Support Services & Community Based Services Referral Form

Date of Referral: _____

Health Home Care Coordinator/ Recovery Coordinator	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Parent /Advocate Information	**First Name**		**Last Name**	
	Address		**Phone #**	
			Email	
CFTSS/HCBS Participant Information	**First Name**		**Last Name**	
	Soc. Sec. #		**Address**	
	Phone #		**Alternate Phone #**	
	Email Address		**Date of Birth**	
	Primary Language			

CFTSS/HCBS Participant Health Care Information	**Managed Care Organization (MCO) Name**		**MCO ID #**	
	MCO Contact Name		**MCO Phone Number**	
	MCO Contact Email		**Medicaid CIN Number**	
	Primary Diagnosis & ICD 10 Code		**Secondary Diagnosis & ICD 10 Code**	

Any Known Safety Concerns? *(Criminal Record, History of Violence, Weapons in the Home, Sex Offender, General Concerns, etc.):* ☐ *N/A*

Referred CFTSS and HCBS Service(s):

☐ **Other Licensed Practitioner (OLP)**	☐ **Pre- Vocational Services**
☐ **Psychosocial Rehabilitation (PSR)**	☐ **Caregiver Family Support and Services**
☐ **Community Psychiatric Supports and Treatment (CPST)**	☐ **Community Self Advocacy Treatment and Support**
☐ **Family Peer Support and Services**	☐ **Habilitation**
☐	☐ **Supported Employment**
☐	☐ **Respite- Planned**

Any Identified Service Restrictions Surrounding Client Availability? ☐ *N/A*

Below sections are for CFTSS & HCBS Service Provider Affiliates to Complete: **Date Received:**

CFTSS/HCBS Provider Assigned		***Date Assigned***	
CFTSS/HCBS Supervisor			

CFTSS/HCBS AGENCY INFORMATION:

AGENCY NAME:_____ **POINT OF CONTACT:** _____

PHONE:_____ **FAX:** _____

E-MAIL: _____

Additional Resources

For Referring Individuals:

Items you **may** want to include with your referral packet:

- Signed consent for release of medical information with agency listed
- Eligibility assessment – Medical necessity – if available
- LOSD or Authorization number if you have it
- Current treatment plan

For CFTSS/HCBS Providers:

Once you have initial contact with the participant as the HCBS provider, the following information is needed by the Health Home Care Coordinator to help inform the Full Plan of Care:

- Treatment plan
- Frequency, scope, duration
- CFTSS/HCBS Authorization from MCO

Send Referrals for Baker Victory Services to :

jkelley@bakervictoryservices.org