Child Health Plus Referral for Home and Community Based Services (HCBS) to HCBS Provider

Instructions:

This form is specific for Child Health Plus (CHPlus) members. All fields must be completed unless listed as optional or as applicable. The contract agreement between the CHPlus health plan and other entities, would determine who would complete the referral form and follow up with the referred HCBS provider.

Section 1 – Completed by Referring Entity

Child/Youth's Information

Child/Youth Legal Name: _____

Child/Youth Preferred Name: _____

Child/Youth DOB: _____ Gender Identity: _____ Gender Assigned at Birth: ☐ M ☐ F

Child/Youth Phone: _____ Child/Youth Email (optional): _____

Child/Youth Address: _____

Child Health Plus Health Plan: _____

Parent/Guardian/Legally Authorized Representative (P/G/LAR) Information

P/G/LAR # 1 – Please check one of the following:

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name: _____ P/G/LAR Email (Optional): _____

P/G/LAR Phone: _____ ☐ Check this box if the Child and P/G/LAR live together.

P/G/LAR Relationship to Child/Youth: _____

P/G/LAR Address: _____

P/G/LAR # 2 – Please check one of the following:

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name: _____ P/G/LAR Email (Optional): _____

P/G/LAR Phone: _____ ☐ Check this box if the Child and P/G/LAR live together

P/G/LAR Relationship to Child: _____

P/G/LAR Address (If different from above): _____

P/G/LAR # 3– Please check one of the following:

☐ **Parent** ☐ **Guardian** ☐ **Legally Authorized Representative**

P/G/LAR Name _____ P/G/LAR Email (Optional) _____

P/G/LAR Phone: _____ ☐ Check this box if the Child and P/G/LAR live together

P/G/LAR Relationship to Child: _____

P/G/LAR Address: _____

Please indicate how many siblings currently reside in the home: _____

Out of the current siblings who reside in the home, how many are receiving HCBS? _____

☐ Check this box if the child attends school or other educational/vocational program

If applicable, please explain the child's school or educational/vocational program schedule below, including how many hours a week they attend the program in question (i.e., Mon-Fri 8am-1pm, etc.). Please also include other standing appointments, e.g., therapy, medical appointments, OT/PT/ST, CFTSS, Hospice, etc.

School/Education:

Regular appointments/programs:

Extracurricular/Community Activities:

Other Programming/Services/Activities:

For extracurricular or community activities, in the box above, note how many hours a day, week, or month.

In the box below, please note the Summer Programming schedule, if this schedule is different from what is noted in the box above.

Clinical Information

Child/Youth Primary ICD-10 Diagnosis (if applicable): _____

Target Population: ☐ SED ☐ Medically Fragile ☐ DD and Medically Fragile ☐ DD and Foster Care

HCBS Agency Information

HCBS Provider Name: _____ HCBS Provider Phone #: _____

HCBS Provider Address: _____

HCBS Provider Contact Name: _____

Has the family agreed to send a referral to this provider? ☐Yes ☐No

Requested HCBS, Goals, and Objectives

HCBS #1 Referral Request

Please select Children's Waiver HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Supports Services,

Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

HCBS #2 Referral Request

Please select HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

HCBS # 3 Referral Request

Please select HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

HCBS # 4 Referral Request

Please select HCBS being requested/included in this notice

- ☐ Community Habilitation
- ☐ Day Habilitation
- ☐ Caregiver/Family Advocacy and Supports Services
- ☐ Prevocational Services
- ☐ Supported Employment
- ☐ Respite Services (Specify below between Planned and/or Crisis
- ☐ Palliative Care (Specify below between: Massage Therapy, Counseling and Supports Services, Expressive Therapy, or Pain and Symptom Management)

Modality (Check all that apply): ☐ Individual _____

☐ Group _____

If requesting **both** modalities, please note which F/S/D is associated with each modality on the lines provided above.

Desired Goal or Need to be addressed
Family Preferences (Staff Gender/Age/Primary Language, Evening/Weekend Appointments, Time Of Day, Etc.)

Other services member is receiving related to this goal (if applicable)

Describe any known barriers or obstacles to the member's goals (reference which HCBS above if more than one), known strategies to address these barriers, and/or additional information/comments for the HCBS provider regarding the Child/Youth and their family and/or the service(s) requested.

☐ I attest that the member has elected to receive all HCBS requested above.

_____ _____

Signature of Referring Individual Name of Agency

_____ _____ _____

Name (please print): Title: Date: