OLV Human Services
A Father Baker Legacy

Children's Health Home Care Management Referral

Client Information/Referral Source

Child's Name: _____ Referral Date: _____

Preferred Name: _____ Referred By: _____

Address: _____ Referrer Organization: _____

City/State/Zip: _____ Referrer Phone: _____

Phone: _____ Referrer Email: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Transgender

Primary Language: _____

Interpretation Services needed: ☐ Yes ☐ No If yes, specify language _____

How did you hear about OLV Care Management Agency? _____

Do you or anyone in your household have prior military service? ☐ Yes ☐ No ☐ Unknown

Medicaid CIN #: _____ Insurance company name/ID # _____

FOSTER CARE: Is the child currently in foster care?

☐ Yes ☐ No ☐ Unknown If Yes with which agency: _____ _____

Foster Care Worker contact Information: Name _____ Phone: _____

Consent & Service Information

Consent to Refer: 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 under the age of 18 that are married, a parent, or pregnant may provide consent on their own behalf.

Who has provided you with consent to make this referral?

☐ Parent ☐ Guardian ☐ Legally Authorize Representative ☐ Self

Date of Consent: _____

Consenter Information: (Please provide the following information about the person you received consent from to make this referral

First Name: _____ Last Name : _____

Relationship to Child/Youth: _____ Address: _____

Phone: _____ E-mail: _____

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CFTSS Services: Is the child/youth currently receiving CFTSS services?
☐ No ☐ Yes ☐ Unknown (If yes please specify provider name)'_____

Preventive Services Connectivity: Is the child/youth currently receiving preventive services?
☐ No ☐ Yes (please specify provider name): _____

Child/Youth Inpatient Status: Is the child/youth current admitted to an inpatient facility?
☐ No ☐ Yes
If yes, what is the name of the facility? _____ Expected discharge Date? _____

Is Parent In a Health Home? ☐Yes ☐ No ☐Unknown If yes, Parent/Guardian Medicaid CIN # _____

Eligibility Criteria: Check all that apply

**** At least one (1) must be checked to refer Can you provide supporting documentation for eligibility:** ☐ Yes ☐ No **

_____ **Two or more Chronic Conditions** (examples include: asthma, substance use disorder, diabetes, cerebral palsy, sickle cell anemia, cystic fibrosis, epilepsy, spina bifida, congenital heart problems, etc.)

List Qualifying Chronic Conditions: _____

OR
_____ **Serious Emotional Disturbance (SED):** ***single qualifying condition***

OR
_____ **Complex Trauma:** ***single qualifying condition***
The term complex trauma incorporates at least: a. Infants/children/or adolescents' exposure multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure

OR

_____ **HIV/AIDS:** ***single qualifying condition***

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Care Management Needs

At risk for adverse event *(e.g. death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement);*

___Has inadequate social/family/housing support or serious disruptions in family relationships
___Has inadequate or lack of connectivity with healthcare system
___Non-Adherence to treatments or has difficulty managing medications
___Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
___Unaddressed Physical Health Needs
___Has deficits in activities of daily living, learning or cognition issues
___Does not have provider Linkage: ☐ Primary Care Provider ☐ Dental ☐ Behavioral Health ☐Other

Risk Factors - Check All that Apply

___Suicide Ideation/ History ___Violent behavior ___Homicidal Ideation / History ___Repeat ED or Inpatient visits
___Has recently been released from incarceration, placement, detention, or psychiatric hospitalization

Care Management Provider Preference (check one): □ No Preference
□ OLV Human Services □ Catholic Charities □ OISHEI □ Best Self □ GBAUHN □ Hillside

Scan and e-mail to: brudy@olvhumanservices.org **or** Fax to: 716 828-9685 attention: Birgit Rudy **or** Mail to: OLV Human Services, 3rd Floor Care Coordination, 790 Ridge Road, Buffalo, New York 14218

For Office Use Only:

Referral accepted on: _____
Assigned to Care Coordinator on: _____ Staff: _____

Comments: