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CFTSS/HCBS Referral

Compeer Office Use Only:
Date received: _____
By: _____

Service(s) Requested: ☐ Psychosocial Rehabilitation/Skillbuilding ☐ Family Peer Support Services ☐ Family Caregiver Support (HCBS) ☐ Youth Peer Support and Training (YPST)

Service Delivery Preference: ☐ In-Person ☐ Telehealth

Date:	Referring Provider/Agency:		
Provider Phone:	Provider E-mail:		
Is parent/guardian aware referral has been made? ☐ Yes ☐ No (explain):			
Child/Youth Name:	Parent/Guardian Name:		
Phone:	E-mail:		
Street Address:	City/State:	Zip:	County:
DOB:	Gender: ☐ M ☐ F ☐ Other	Race/Ethnicity:	School:
Alternative Contact (if applicable) Name:			Phone:

System(s) of Care: ☐ OMH ☐ OPWDD ☐ Special Education ☐ Probation ☐ Substance Use/ OASAS ☐ PINS/Diversion ☐ Juvenile Justice ☐ DOH/Early Int. ☐ CPS ☐ Preventative ☐ Other:	Child/Youth Insurance: ☐ Medicaid ☐ Medicaid Managed Care ☐ 3rd Party/HMO ☐ Other: ☐ Unknown
	Carrier/MCO: ☐ Excellus ☐ MVP ☐ United Healthcare ☐ Fidelis ☐ Other: ☐ Unknown
	Policy #:
	CIN:
Primary Mental Health Diagnosis (ICD-10 if known):	List other involved agencies/services if known:
Symptomatic Behaviors/Safety Concerns:	

Reason for Referral (please describe and/or use the following goal categories):

Youth/Child ☐ Social/interpersonal ☐ Daily living skills ☐ Community Integration ☐ Other

Parent/Caretaker ☐ Self-advocacy ☐ Skill development ☐ Natural Supports ☐ Educational advocacy ☐ Access to resources ☐ Other

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Medical Necessity Form - LPHA Recommendation for Children & Family Treatment & Support Services/Children's Home and Community Based Services

Instructions: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (Individual currently licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Licensed Creative Arts Therapist, or Physician).

Recommendation for Rehabilitative Service(s)

Participant Name:	Date of Birth:
Parent/Caregiver:	Relationship:
Address:	Phone:
County of Residence:	Medicaid CIN #:

Behavioral Health Information: (*A MH/SUD diagnosis is only required for a recommendation of PSR) *Check all that apply:*

List	Diagnosis Category	Specific Diagnosis or Symptoms of Mental Illness DX Code(MH)/Substance Use (SUD)	Code
Primary			
Secondary			
Other			

Areas of Functioning: (As a result of the symptoms or diagnosis of MH/SUD, the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.) *Check all that apply:*

Check	Domain	Description of Impairment
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended Child and Family Treatment and Support Service(s): *Check all that apply:*

Check	Rehabilitative Service	Description of needed intervention
	Psychosocial Rehabilitation (Skillbuilding)	
	Family Peer Support	
	Caregiver /Family Support (HCBS)	

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Medical Necessity Form - LPHA Recommendation for Children & Family Treatment & Support Services/Children's Home and Community Based Services

Detailed Reason for Recommendation:

By Signing below I am recommending the above named individual for Child and Family Treatment Support Services:

LPHA Signature	Printed Name	NPI #	Date