

Community-Based Services Referral

Children and Family Treatment and Support Services

Referring Individual

Date of referral _____

Name _____
Agency name _____
Address _____
Phone _____ Email _____

Health Home Care Coordinator Information (if applicable)

Name _____
Agency name _____
Address _____
Phone _____ Email _____

Participant Information

Name _____
Address _____
Parent or caregiver name _____
Phone _____ Email _____
Alternate phone _____ Primary language _____
Gender Male Female Other Date of birth _____

Participant Health Care Information

Managed care organization (MCO) _____ MCO Id number _____
MCO contact name _____ MCO email _____
MCO phone number _____ Medicaid CIN _____
Primary diagnosis & ICD 10 code _____ Secondary diagnosis & ICD 10 _____
Are there any known safety concerns (i.e., criminal record, history of violence, weapons in the home, sex offender, general or other concerns, etc.)? Yes No If yes, briefly describe: _____

Referred Children and Family Treatment and Support Services:

- | | |
|--|--|
| <input type="checkbox"/> Other Licensed Practitioner (OLP) | <input type="checkbox"/> Psychosocial Rehabilitation (PSR) |
| <input type="checkbox"/> Community Psychiatric Supports and Treatment (CPST) | <input type="checkbox"/> Family Peer Support Services (FPSS) |
| <input type="checkbox"/> Youth Peer Support and Training (YPST) | <input type="checkbox"/> Crisis Intervention (CI) |

Indicate any additional information that may be important to know: _____

Has this child been hospitalized in the last 30 days? Yes No Is this child stepping down from RTF placement? Yes No

If Other Licensed Practitioner (OLP) was checked above, please check all that apply indicating the preference of OLP service

- OLP Assessment: To determine CFTSS medical necessity
 OLP Assessment: To determine Health Home Care Management eligibility
 OLP Home and Community-Based individual and family counseling

Referring individuals may want to include these items with the completed referral submission:

- ✓ Signed release
- ✓ Preliminary plan of care
- ✓ Medical necessity documentation
- ✓ Any other pertinent information (e.g., proof of diagnosis, medication, family history)

Agency Information

All referrals sent to Northern Rivers will be served by its affiliate Northeast Parent & Child Society.
Please send referrals to Donna Cole at Donna.Cole@nrfs.org or by fax to 518.372.3793

For questions, contact:

Barb Fuscus, Director, Barbara.Fuscus@nrfs.org
Jacob Malison, Director, Jacob.Malison@nrfs.org
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