## **Adult Home and Community-Based Services Referral**

Northeast Parent & Child Society	Referral To	Date of referral
Health Home Care Coordinator Information (if applicable)   Name	□ Northeast Parent & Child Society	
Agency name Address Phone	Referring Individual	
Agency name Address Phone	Name	
Participant Information Name	Agency name	
Health Home Care Coordinator Information (if applicable)  Name		
Name   Agency name   Address   Femail   Participant Information   Alternate phone   SSN   Address   Phone   Alternate phone   Date of birth   Participant Health Care Information   Alternate phone   Date of birth   Participant Health Care Information   MCO email   MCO demail   MCO phone number   McO email   MCO phone number   Medicaid CIN   Primary clare physician   Phone   Alternate phone   Primary care physician   Phone   Address   Phone   Pho	Phone	Email
Agency name Address   Femail    Participant Information Name		
Address   Email   Participant Information   SSN   Address   Phone   SSN   Alternate phone   Date of birth   Participant Health Care Information   MCO email   MCO ontact name   MCO ontact name   MCO open on umber   Medicaid CIN   Primary cliangosis & ICD 10 code   Secondary diagnosis & ICD 10   Primary care physician   Phone   Address   Phone   Primary diagnosis & ICD 10   Primary diagnosis & ICD 10   Primary care physician   Phone   Primary		
Participant Information Name		
Name		
Name	Particinant Information	
Address   Phone		SSN
Phone		
Participant Health Care Information  Managed care organization (MCO)		
Participant Health Care Information  Managed care organization (MCO)		
Managed care organization (MCO)		
MCO contact name MCO email McO phone number Medicaid CIN Secondary diagnosis & ICD 10 December Medicaid CIN Primary diagnosis & ICD 10 code Secondary diagnosis & ICD 10 Primary care physician Phone Address Physician Phone Phone Phone Phone Phone McGostribe any known safety concerns (i.e., criminal record, history of violence, weapons in the home, sex offender, general or other concerns, etc.) Adult Habilitation Adult Employment Support Services Pre-Vocational Adult Employment Support Services Pre-Vocational Adult Transitional Employment Indicate any services restrictions surrounding client availability Referring individuals may want to include these items with the referral submission:  **Signed releases** Eligibility assessment summary report (from UAS)** Preliminary plan of care LOSD or authorization number if available  **HCBS Agency Information**  **Agency Contact name Phone Fax**	•	
McGo phone number		
Primary diagnosis & ICD 10 code		IVICO email
Primary care physician		
Address Psychiatrist or therapist		
Psychiatrist or therapist		
Address Briefly describe any known safety concerns (i.e., criminal record, history of violence, weapons in the home, sex offender, general or other concerns, etc.)    Referred Home and Community-Based Services		
Briefly describe any known safety concerns (i.e., criminal record, history of violence, weapons in the home, sex offender, general or other concerns, etc.)    Referred Home and Community-Based Services		
Adult Habilitation	Briefly describe any known safety concerns	(i.e., criminal record, history of violence, weapons in the home, sex offender, general or
✓ Signed releases ✓ Eligibility assessment summary report (from UAS) ✓ Preliminary plan of care ✓ LOSD or authorization number if available  HCBS Agency Information Agency	<ul><li>☐ Adult Habilitation</li><li>☐ Adult Employment Support Services Pre</li><li>☐ Adult Educational Support Services</li></ul>	Adult Intensive Supported Employment  -Vocational Adult Ongoing Supported Employment  Adult Transitional Employment
Agency Contact name Phone Fax	<ul> <li>✓ Signed releases</li> <li>✓ Eligibility assessment summary report (</li> <li>✓ Preliminary plan of care</li> </ul>	(from UAS)
Agency Contact name Phone Fax	HCBS Agency Information	
Phone Fax		Contact name



## **Home and Community-Based Services Referral**

Additional Resources

## **HCBS Providers**

Once initial contact is made with the participant, as the HCBS provider, you will need to send the following information to the Health Home Care Coordinator to help inform the full plan of care:

- ✓ Updated goals
- ✓ Frequency, scope, duration
- ✓ Date of initial contact
- ✓ HCBS authorization from MCO

## **Health Home Care Coordinator**

The Health Home Care Coordinator will need to send the HCBS provider the final, signed plan of care at a later date.

