**Children’s Health Home Community Referral Form**

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| **Youth Name:** | **Parent/Guardian/Legal Representative:** | **Relationship to Youth:** | **Date:** |
| **Date of Birth:** | **Gender:****[ ]  Male [ ]  Female [ ]  Other** | **County of Residence:** |
| **Address:** | **Phone:** |

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| **Yes** | **No** | **Eligibility Requirements** |
| [ ]  | [ ]  | **Youth Has Active Medicaid** | **Medicaid CIN # REQUIRED :** (ex: EF58916M) |
| [ ]  | [ ]  | **Youth Meets NYS DOH Eligibility Criteria:**[ ]  Two Chronic Health Conditions *or*[ ]  HIV/AIDS *or*[ ]  Serious Emotional Disturbance *or*[ ]  Complex Trauma (please also include complex trauma face sheet and screen) | **Diagnosis:** (attach documentation if available) |
| [ ]  | [ ]  | **Youth has significant behavioral, medical or social risk factors, which can be addressed through Care Management.** | **Summary of Concerns or Needs:** |

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| **Preferred or Recommended Care Management Agency**:[ ]  Transitional Services Association |

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| **To the Best of Your Knowledge, is this Youth involved in**: |
| [ ]  Counseling[ ]  Foster Care (LDSS must complete referral form)[ ]  Specialized Medical Care[ ]  Psychiatric Services (prescribed medications)[ ]  Inpatient psychiatric hospitalizations (consider SPOA Referral) | [ ]  CSE Services[ ]  DSS Child Protective Services[ ]  DSS Child Preventative Services[ ]  Probation/PINS Diversion[ ]  Other: |

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| 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 ages 18-21, or that are married, a parent, or are pregnant may provide consent on their own behalf. Who has provided you with consent to make this referral? *(please check one)*[ ]  Parent [ ]  Guardian [ ]  Legal Representative [ ]  Child who is (circle one): 18 years or older A Parent Pregnant Married |
| **Name of Consenter:** |

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| **Referring Party Name:** | **Agency:** |
| **Phone:** | **Email:** |

**Fax and/or Email Completed Referral Form to**: (please attach any supporting documentation if available)

Transitional Services Association

Child & Youth Care Management

127 Union Street, Saratoga Springs NY 12866

(P) 518-583-3640 **(F) 518-583-3681**

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