|  |
| --- |
| **Date of Referral:**  |
| **Referring Person** | **First Name:** |  | **Last Name:** |  |
| **Agency Name:** |  | **Phone #:** |  |
| **Address:** |  | **Email:** |  |
| **Health Home Care Coordinator Information** | **First Name:** |  | **Last Name:** |  |
| **Agency Name:** |  | **Phone #:** |  |
| **Address:** |  | **Email:** |  |
| **HCBS/CORE Participant Information** | **First Name:** |  | **Last Name:** |  |
| **Soc Sec #:** |  | **Address:** |  |
| **Phone #:** |  |  |
| **Alt Phone #:** |  | **Email:** |  |
| **Date of Birth:** |  | **Language:** |  |
| **HCBS/CORE Participant Health Care Information** | **MCO Name:** |  | **MCO ID#:** |  |
| **MCO Contact Name:** |  | **MCO Phone:** |  |
| **MCO Contact Email:** |  | **Medicaid CIN:** |  |
| **Primary Dx and ICD 10:** |  | **Secondary DX/ICD 10:** |  |
| *\*Please attach supporting documentation of diagnoses if you have it* |
| **Any Known Safety Concerns?** *(Criminal Record, History of Violence, Weapons in the Home, Sex Offender, General Concerns, etc.):*  [ ]  N/A |

|  |  |
| --- | --- |
| Referred HCBS Service(s) | Referred CORE Service(s) |
|  [ ]  Habilitation |  [ ]  Psychosocial Rehab (PSR) |
|  [ ]  Education Support Services |  [ ]  Family Support and Training |
|  [ ]  Pre-vocational Services |  [ ]  Empowerment Services – Peer Supports |
|  [ ]  Transitional Employment |  [ ]  Community Psychiatric Support and Treatment (CPST) |
|  [ ]  Intensive Supported Employment |
|  [ ]  Ongoing Supported Employment |  |
|  |  |
| Any identified service restrictions surrounding client availability? [ ]  N/A |

***Below sections are the for HCBS/CORE Service Provider Affiliate to Complete***

|  |  |  |  |
| --- | --- | --- | --- |
| *HCBS/CORE Provider Assigned:* |  | *Date Received:* |  |
| *HCSB/CORE Supervisor:* |  | *Date Assigned:* |  |

**HCBS/CORE AGENCY INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| *Agency:* |  | *Point of Contact:* |  |
| *Phone:* |  | *Fax:* |  |
| *Email:* |  |

**Additional Resources**

**For Referring Individuals:**

Items you may want to include with your referral packet:

|  |  |
| --- | --- |
| For HCBS Referrals | For CORE Referrals |
| * Signed releases
 | * Signed releases
 |
| * Eligibility assessment summary report (from UAS)
 | * LPHA Recommendation Form if you have it
 |
| * Preliminary Plan of Care
 |
| * LOSD or Authorization number if you have it
 |  [ ]  **Check here if you are unable to secure an LPHA Recommendation Form** |

**For HCBS Providers:**

Once you have initial contact with the participant as the HCBS provider, the following information is needed by 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

\*Note this is NOT required for CORE Services

**For Health Home Care Coordinator / HCBS Provider:**

* For Members receiving HCBS, please send the final/signed Plan of Care to the MCO once all portions of the Full Plan of Care are completed by the Care Coordinator and HCBS Provider.