SCO Family of Services

Extraordinary reach.
Unconditional care.
Life-changing results.

Please submit all completed forms to homebasedsupports@sco.org

# Children and Family Treatment and Support Services & Home and Community Based Services Referral Form

**T:** 718-312-6829 **Fax:** 718-523-1901 **Email:** homebasedsupports@sco.org

| | | | | |
|---|---|---|---|---|
| **Date of Referral** | | ☐ Internal SCO Referral | ☐ External Referral | |
| **Provider Making Referral** | **First Name** | | **Last Name** | |
| | **Agency Name** | | **Title** | |
| | **Phone #** | | **Email** | |
| | **Address** | | | |
| | **Referral Provider NPI#** | | **Referral Provider License #** | |
| | **License Type** | | | |
| **Consenter Information** | **Consenter Name** | | **Phone #** | |
| | **Relationship to Youth** | | **Preferred Time/ Method of Contact?** | |
| | **Consenter Address** | | | |
| **Health Home Care Coordinator Information** *if applicable | **First Name** | | **Last Name** | |
| | **Agency Name** | | **Phone #** | |
| | **Address** | | **Email** | |
| **Participant Information** | **First Name** | | **Last Name** | |
| | **Gender** | ☐ Male ☐ Female | **Date of Birth** | |
| | **Caregiver** | | **Primary Language** | |
| | **Caregiver Relationship** | | **Foster Care Status** | ☐ In-Care ☐ Out Of Care |
| | **Phone #** | | **Alternate Phone #** | |
| | **Email** | | **County** | |
| | **Address** | | | |
| **Provider Information** | **School Name** | | **School Address** | |
| | **Date of Last IEP** *If Applicable | | **Grade** | |

SCO Family of Services

Extraordinary reach.
Unconditional care.
Life-changing results.

| | | | | |
|---|---|---|---|---|
| | **Pediatrician/ Doctor Name** | | **Pediatrician/ Doctor Address** | |
| | **Is youth actively engaged in mental health counseling?** ☐ **Yes** ☐ **No** | | | |
| | **Mental Health Therapist** | | **Provider Agency** | |
| | **Specialist/Additional Provider** | | **Provider Agency** | |

| | | | | |
|---|---|---|---|---|
| **Participant Health Care Information** | **Managed Care Organization (MCO)** | | **MCO ID #** | |
| | **MCO Contact Name** | | **MCO Phone Number** | |
| | **MCO Contact Email** | | **Medicaid CIN Number** | |
| | **Primary Diagnosis & ICD 10 Code** | | **Secondary Diagnosis & ICD 10 Code** | |

**Please list all known prescribed medications (Name, Dosage, Regimen):**

**Symptoms of Concern**

***Check all that apply**

Symptoms of Concern

| | | | | |
|---|---|---|---|---|
| ☐ Depression | ☐ Anxiety | ☐ Phobia | ☐ Danger to self | ☐ Danger to other |
| ☐ Temper tantrums | ☐ Sleep | ☐ Enuresis/Encopresis | ☐ Physical Aggression | ☐ Alcohol use |
| ☐ Developmental Delays | ☐ Sexually Inappropriate | ☐ Sexually Aggressive | ☐ Verbal Aggression | ☐ Drug use |
| ☐ Physically Aggressive | ☐ Eating Disturbances | ☐ Hyperactivity | ☐ Impulsive | ☐ Runaway |
| ☐ Self-injury | ☐ Delinquent behavior | ☐ Problematic Social Beh. | | |
| ☐ Negative Peer Interactions | | ☐ Attention Defecits | | |

**Any Known Safety Concerns?** *(Criminal Record, History of Violence, Weapons in the Home, Sex Offender, General Concerns, etc.):*

**Why is the youth being referred for services:**

**Any Identified Service Restrictions Surrounding Client Availability:**

**Referred HCBS Service(s):**

| Service Requested | Units (Per Month) | Day/Time for Services |
|---|---|---|
| **Community Habilitation** | | |
| ☐ Individual ☐ Group | | |
| **Respite** ☐ Planned ☐ Crisis | | |
| ☐ Individual ☐ Group | | |
| **Caregiver/Family Supports and Services** | | |
| ☐ Individual ☐ Group | | |
| **Habilitation** ☐ Day ☐ Community | | |

SCO Family of Services

Extraordinary reach.
Unconditional care.
Life-changing results.

| | | |
|---|---|---|
| ☐ Individual ☐ Group | | |
| **Community Self-Advocacy Training and Supports** | | |
| ☐ Individual ☐ Group | | |
| **Prevocational Services** | | |
| ☐ Individual ☐ Group | | |
| **Supported Employment** | | |
| ☐ Individual ☐ Group | | |
| **Referred CFTSS Service(s):** | | |
| **Service Requested** | **Units (Per Month)** | **Day/Time for Services** |
| **Psychosocial Rehabilitation (PSR)** | | |
| ☐ Individual ☐ Group | | |
| **Other Licensed Practitioner (OLP)** | | |
| ☐ Individual ☐ Group | | |
| • **OLP Licensed Evaluation** | | |
| • **OLP Counseling Individual** | | |
| • **OLP Crisis** | | |
| • **OLP Crisis Triage** | | |
| **Community Psychiatric Treatment and Supports (CPST)** | | |
| ☐ Individual ☐ Group | | |
| • **Intensive Interventions** | | |
| • **Crisis Avoidance** | | |
| • **Intermediate Term Crisis Management** | | |
| • **Rehabilitative Psycho-education** | | |
| • **Strength-Based Service Planning** | | |
| • **Rehabilitative Supports** | | |
| **Family Peer Support (FPS)** | | |
| ☐ Individual ☐ Group | | |
| **Youth Peer Support (YPS)** | | |
| ☐ Individual ☐ Group | | |

| **Worker Requirements** | | | | | |
|---|---|---|---|---|---|
| **Language Preference** | | **Worker Gender Preference** | | **Is the family comfortable with more than one worker?** | ☐ **Yes** ☐ **No** ☐ **If-Need-Be** |
| **Additional Comments or Alerts** | | | | | |

| **Below sections are for CFTSS/HCBS Service Provider Affiliate to Complete:** | ***Date Received:*** | | |
|---|---|---|---|
| ***CFTSS Supervisor Assigned*** | | ***Date Assigned*** | |
| ***CFTSS Provider(s) Assigned*** | | ***Date Assigned*** | |
| ***HCBS Supervisor Assigned*** | | ***Date Assigned*** | |
| ***HCBS Provider(s) Assigned*** | | ***Date Assigned*** | |

**For Referring Individuals, Please Attach the Following:**

- Medicaid Card
- MCO Plan Card
- Signed releases
- Preliminary Plan of Care
- Level of Care
- Medical Necessity Documentation
- Evaluations (e.g., Psychosocial, Psychiatric, IEP, Etc.)
- Other Pertinent Family Information