CHJC Human Services & Community-Based Programs

For Adult Referrals:
Phone: (315) 788-7430
Fax: (315) 777-9770
Email: adultcarecoordination@chjc.org

For Children's Referrals:
Phone: (315) 788-7430
Fax: (315) 777-9770
Email: childrencarecoordination@chjc.org

Referral Form for Care Coordination Services (Adult and Child)

DEMOGRAPHICS

Date of Referral:	Date of Birth:	Gender:
Name (Last, First, MI.):		
Address:		**Phone:**

INSURANCE

Medicaid CIN #:	Managed Care Organization Plan:

CONSENT TO REFER (Children only)

CONSENT TO MAKE THIS REFERRAL MUST BE OBTAINED FROM THE PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE FOR CHILDREN UP TO THE AGE OF 18. CHILDREN/YOUTH AGES 18-21, OR THOSE WHO ARE MARRIED, A PARENT, OR PREGNANT, MAY CONSENT ON THEIR OWN BEHALF. Who has provided you with consent to make this referral?

☐ Parent	☐ Guardian	☐ Legally Authorized Representative	☐ Child/Youth (18 - 21 yrs. old, Parent, Pregnant or Married)

Name of Consenter:	Signature:

HEALTH HOME ELIGIBILITY (Adult and Child)

Why is the referent seeking Case Management Services?

Additional Notes:

Appropriateness Criteria (Check all that apply)

- ☐ At risk for adverse event (death, disability, inpatient or nursing home admission, mandated preventative services, or out of home placement)
- ☐ Has inadequate social/family/housing support or serious disruptions in family relationships
- ☐ Has inadequate connectivity with a healthcare system
- ☐ Does not adhere to treatments or had difficulty managing medications
- ☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- ☐ Has deficits in activities of daily living
- ☐ Learning or cognition issues
- ☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

Please attach all supporting documentation including diagnosis/qualifying condition

REFERRAL SOURCE

Name:	Title:	Organization:
Phone:	**Email:**	