Adult Behavioral Health Home & Community Based Services Referral Form

Date of Referral: ___________________________ **Updated by the RPC 10/4/18*

Referring Person	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Health Home Care Coordinator/ Recovery Coordinator Information	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
HCBS Participant Information	**First Name**		**Last Name**	
	Soc. Sec. #		**Address**	
	Phone #		**Alternate Phone #**	
	Email Address		**Date of Birth**	
	Primary Language			

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

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

Referred HCBS Service(s):

☐ **Habilitation**	☐ **PSR**
☐ **Pre-Vocational Services**	☐ **Family Supports & Training**
☐ **Community Psychiatric Supports and Treatment (CPST)**	☐ **Empowerment Services (Peer Supports)**
☐ **Short Term Crisis Respite**	☐ **Intensive Crisis Respite**
☐ **Transitional Employment**	☐ **Intensive Supported Employment**
☐ **Ongoing Supported Employment**	☐ **Education Support**

Any Identified Service Restrictions Surrounding Client Availability? ☐ *N/A*

Below sections are for HCBS Service Provider Affiliate to Complete: **Date Received:**

BH HCBS Provider Assigned		***Date Assigned***	
BH HCBS Supervisor			

HCBS AGENCY INFORMATION:

AGENCY NAME: ______________________________ POINT OF CONTACT: ______________________________

PHONE: ______________________________ FAX: ______________________________

E-MAIL: ______________________________

Additional Resources

For Referring Individuals:

Items you may want to include with your referral packet:

- Signed releases
- Eligibility assessment summary report (from UAS)
- Preliminary Plan of Care
- LOSD or Authorization number if you have it

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

Items you will need to send as the Health Home Care Coordinator to the HCBS provider at a later date:

- Final/signed Plan of Care