Transfer Referral for C-YES, Health Homes, and Care Management Agencies

The following is to be completed for transfers between the Health Homes and the Children and Youth Evaluation Services (C-YES). Additionally, all required documents must accompany this referral form. A determination of the effective transfer date must occur between the Health Home and C-YES, so each party is aware when their responsibility ends and the other begins. Documentation of such date and the notification to the family must occur.

Identifying Information

Child's Name *(Last, First, MI)*:	Date of Birth:	Gender:
Parent/Guardian/Legally Authorized Representative Name:		
Current Address:	Medicaid CIN #:	
	Medicaid Managed Care Plan Name (if applicable):	
	County of Residence:	
Parent/Guardian Phone:	Parent/Guardian Phone Cell Phone (if applicable):	
Email:		
Indicate any need for language/interpretation services; specify language spoken if other than English:		
Date Discussion of Transfer Occurred with the child/youth/family: _____ Reason for Transfer: _____ _____ ☐ The child/youth/family was referred and determined that they wanted to be served by the other, limited information/work was completed with the family and this form will be incomplete		

Children's Waiver Information:

Home and Community Based Services/Level of Care (HCBS/LOC) Completion Date: _____ Was the UAS Outcomes Signed: ☐ Yes ☐ No Date K-Codes on the Member's file: _____ DATE ☐ K1 ☐ K3 ☐ K4 ☐ K5 ☐ K6	Target Population ☐ Serious Emotional Disturbance (SED) ☐ Medically Fragile (MF) ☐ Developmental Disabilities (DD) and Medically Fragile (MF) ☐ Child/Youth has met DD eligibility - Date _____ ☐ Child/Youth has met OPWDD LCED -Date _____ ☐ Developmental disabilities (DD) and Foster Care ☐ Child/Youth has met DD eligibility - Date _____ ☐ Child/Youth has met OPWDD LCED -Date _____
☐ NYS DOH Capacity Management Approved Slot Date of the Slot approval _____ DATE	

Medicaid Information:

Medicaid Date: _____ Medicaid Recertification Date: _____ Family of One? ☐ Yes ☐ No If yes, verify the RE code of **KK** is on members file: ☐ Yes ☐ No

Foster Care:

Is the child/youth currently in foster care? ☐ Yes ☐ No In the custody of what county? _____
If yes, placed at what agency/facility/foster home? Please Provide, Name, Address, Contact Information
If no, was the child/youth previously in foster care when entering the waiver (Either the Children's Waiver or B2H)? ☐ Yes ☐ No Please provide date information: _____

Contact Information for Person Completing the Transfer Referral:

☐ Children and Youth Evaluation Services (C-YES) ☐ Lead Health Home (HH) ☐ HH Care Management Agency (CMA)		
Contact's Name:	Contact's Title:	
Contract Organization:	Contact's Address:	
Phone:	Email:	HCS Name:
Is there a preferred HH CMA requested by the child/youth/family? ☐ Yes ☐ No Name of Agency: _____ Contact Information if Known:		
Has there been or currently involved agency that should be considered? ☐ Yes ☐ No Name of the Agency: _____ Contact Information if Known:		

Narrative

Provide any additional information that may be helpful in assignment or regarding the transfer:

Plan of Care (POC) and HCBS:

Is there a POC already developed and signed by the client/parent/guardian/legally authorized representative?
☐ Yes ☐ No
If no, please explain:
_____
_____

Please Check all the HCB Services on the POC and their respective status and goal?
☐ **Community Habilitation:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Day Habilitation:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Caregiver/Family Support and Services:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Community Self Advocacy Training Support:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Prevocational Services:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Supported Employment:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Respite Services:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

☐ **Palliative Care:** ☐ Referral has been made ☐ Referral been accepted ☐ Member in Services
☐ **Massage,** ☐ **Bereavement,** ☐ **Expressive,** ☐ **Pain/Symptom Management**
Desired Goal or Need To be Addressed: _____
Reason Referral not made or capacity issue? _____
_____

Required Documentation to Accompany this Transfer Referral:
Please provide the following information and any additional materials, as allowable per the proper consent:

☐ Copy of the **Opt-in** form if transferring from C-YES to Health Home

☐ Copy of the **Opt-out** form (or the "Withdrawal of Consent Form", the disenrollment letter if already used by the HH) if transferring from Health Home to C-YES

☐ Copy of the Plan of Care

☐ Copy of Referrals to HCBS Providers, if applicable

☐ Copies of Documentation to support HCBS/LOC Determination by Target Population
- ☐ Serious Emotional Disturbance (SED) Diagnosis
- ☐ Medically Fragile (MF)
  - ☐ SSI document OR
  - ☐ Certificate of Disability OR
  - ☐ The 3 completed forms of DOH – 5151, 5152, and 5153
- ☐ Developmental Disability Medically Fragile
  - ☐ DD eligibility document DDRO Region Involved: _____
  - ☐ OPWDD LCED document
- ☐ Developmental Disability in Foster Care
  - ☐ DD eligibility document DDRO Region Involved: _____
  - ☐ OPWDD LCED document

☐ Copy of the Licensed Practitioner of the Healing Arts (LPHA) Attestation form when required by the target population

☐ Copy of the Freedom of Choice Form

☐ Documentation to support the ratings and HCBS/LOC eligibility determination

☐ Consent forms ☐ Functional Consent form ☐ Providers Consent form

☐ Copy of the Notice of Decision (NOD)

☐ Any relevant notes or documents other than listed above (if, applicable)

Notification of Transfer: Check all Entities that have been notified of the transfer

Managed Care? ☐ No ☐ Yes All HCBS providers? ☐ No ☐ Yes
Others: _____

PLEASE NOTE:
It is necessary for the transferring entity to obtain consent from the child/youth/family to share information with the receiving entity. *Clinical documentation from a third party may not be released in certain circumstances and may need a re-release. Additionally, coordination of a warm hand-off three-way call with the transferring and receiving entities and the child/youth/family. Subsequently, an agreed upon transfer date where one entity is no longer responsible, and the other entity takes the responsibility. On the date of transfer, all appropriate R/RE codes (K and A Codes) must be on the members file.