Baker Victory Services Children’s Health Home Care Management Referral

Baker Victory Services- Children’s Health Home is accepting referrals for children and youth ages 0-21. Individuals must meet the eligibility requirements below, in order to be considered for enrollment.

Children’s Health Home Care Management eligibility requirements:

1. Currently have active Medicaid;  
   AND
2. Reside in Erie County or Niagara County  
   AND
3. Have two or more chronic conditions, or has a single qualifier of: HIV/AIDS, complex trauma, or has a serious emotional disturbance

If the child/youth is currently enrolled in one of the programs below, or has a condition listed below, he/she is not eligible to receive Home Health Care Management services:

- OPWDD waiver program
- Long Term Home Health Care (LTHHCP)
- Reside in an ICF-DD facility
- Resides in nursing home
- Traumatic Brain Injury

How to Make a Referral to Baker Victory Services- Children’s Health Home program

1. Complete the attached referral, and be sure to include the individuals Medicaid ID/Medicaid CIN number.
2. Return the completed referral to Sheila Hunt via secure e-mail or fax. Referrals can be emailed or faxed to information below:
   
   E-mail: shunt@bakervictoryservices.org  
   Fax: 716-828-9685 (Attn: Sheila Hunt)

Once the referral is received a Care Manager will contact the family and arrange a home visit. If you have any questions, please contact Baker Victory Services- Children’s Health Home at 716-828-9699.
**Health Home Referral Guidelines**

The child must have **Active Medicaid or Medicaid Managed Care** AND Two chronic medical conditions OR One single qualifying condition such as:
A. HIV/AIDS
B. SED (Serious Emotional Disturbance)
C. Complex Trauma
AND
Child/youth has significant behavioral, medical or social risk factors which can be addressed through care management

**Referral Source Information**

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<th>Referral Source Name:</th>
<th>Date of Referral:</th>
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<th>Organization:</th>
<th>Department:</th>
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**Client Information**

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<tr>
<th>Child’s Name:</th>
<th>Date of Birth:</th>
<th>Gender:</th>
<th>Medicaid CIN #:</th>
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<th>Current Address:</th>
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<th>Insurance company name:</th>
<th>County of Residence:</th>
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<th>Phone:</th>
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<th>Is there language or interpretation service needs:</th>
<th>Yes; specify language</th>
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<td>Y</td>
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**FOSTER CARE: Is the child currently in foster care?**

- ___ Yes, If Yes with which agency ______________________
- ___ No
- ___ Unknown

**Consent & Service Information**

**Consent to Refer:** Consent to make this referral must be obtained from the parent/guardian/legally authorized representative for children up until the age of 18. Children/youth ages 18-21 that are married, a parent, or pregnant may provide consent on their own behalf.
Who has provided you with consent to make this referral?
☐ Parent  ☐ Guardian  ☐ Legally Authorize Representative
☐ Child/Youth who is (circle one): 18 years or older; A parent; Pregnant or Married
Date of Consent: __________________

Consenter Information: (Please provide the following information about the person you received consent from to make this referral)
First Name: ____________________________  Last Name: ____________________________
Relationship to Child/Youth: ____________________________  Telephone Number: ____________________________
Address: ____________________________

Preventive Services Connectivity: Is the child/youth currently receiving preventive services?
☐ No  ☐ Yes (please specify provider name): ____________________________

Child/Youth Inpatient Status: Is the child/youth current admitted to an inpatient facility?
☐ No  ☐ Yes
If yes, what is the name of the facility? ____________________________  Expected discharge Date: ____________________________
Is Parent In a Health Home?  ___Yes  ___No  __Unknown  If Yes Parent/Guardian Medicaid CIN ____________________________

Eligibility Criteria: Check all that apply

** At least one (1) must be checked to refer  *** Please provide any supporting documentation that confirms eligibility

☐ Two or more Chronic Conditions (examples include: asthma, substance use disorder, diabetes, cerebral palsy, sickle cell anemia, cystic fibrosis, epilepsy, spina bifida, congenital heart problems, etc.)
List Qualifying Chronic Conditions: __________________________________________________________

OR

☐ Serious Emotional Disturbance (SED): single qualifying condition

SED is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following (DSM) categories
(Schizophrenia Spectrum and Other Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders, Anxiety Disorders, Obsessive-Compulsive and Related Disorders, Trauma-and Stressor-Related Disorders, Dissociative Disorders, Somatic Symptom and Related Disorders, Feeding and Eating Disorders, Gender Dysphoria, Disruptive, Impulse-Control, and Conduct Disorders, Personality Disorders, Paraphilic Disorders)
AND has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

OR

☐ Complex Trauma: single qualifying condition

The term complex trauma incorporates at least:
a. Infants/children/or adolescents’ exposure multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure

OR

☐ HIV/AIDS: single qualifying condition
At risk for adverse event (e.g. death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement);

___ Has inadequate social/family/housing support, or serious disruptions in family relationships;
___ Has inadequate connectivity with healthcare system;
___ Does not adhere to treatments or has 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; OR

Provider Linkage:  Primary Care Provider       Dental       Behavioral Health       Other

Risk Factors - Check All that Apply
___ Suicide Ideation/ History                     ___ Violent behavior
___ Homicidal Ideation / History                   ___ Repeat ED or Inpatient visits
___ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;