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.

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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

Referral Source Name: ______________________________ Date of Referral: ________________________

Organization: _____________________________________ Department: ___________________________

Email: ____ Phone: ________________________________

Client Information

Child's Name: __________________________________ Date of Birth: __________________ Gender: M F T

Current Address: ____ Medicaid CIN #: ____________________

Insurance company name: ____ County of Residence: ________________

Phone: ______________________________ Cell Phone: __________________________

Is there language or interpretation service needs: Y N Yes; specify language _________________________

FOOTER 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 Date of Consent: ___________________

☐ Child/Youth who is (circle one): 18 years or older; A parent; Pregnant or Married

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***

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Care Management Needs

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;