VILLA of HOPE
YOUTH & FAMILY SERVICES
rebuild. recover. renew.

Children's Care Management Referral

Identifying Information:

Child's Name:	Date of Birth:	Gender:
Current Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization:	
	County of Residence:	
Phone Number:	Interpretation Services Needed:	

Consenter Information:

First Name:	Last Name:
Relationship to Youth:	Phone Number:

Referral Source Information:

Name:	Title:
Organization:	
Phone:	Email:

Eligibility:

☐ Two Chronic Conditions (ex: mental health diagnosis, substance use disorder, physical health condition) o List Qualifying Conditions:
☐ Serious Emotional Disturbance (SED) o List Mental Health Diagnosis:
☐ History of Trauma o Include Complex Trauma Screen:

Other Services/Providers Involved:

Provider: Agency:	Service:
Provider: Agency:	Service:
Provider: Agency:	Service:

Risk Factors: (Check all that apply)

☐ At risk for adverse event;

☐ 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

Narrative:
What would they like to work on/accomplish? Provide any additional information that may be helpful.

*** Please attach any diagnosis documentation if applicable ***

Email completed referrals to: CaseManagement@villaofhope.org

OR Fax to 585-328-0815