IN-HOME BEHAVIORAL INTERVENTION REFERRAL FORM

THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

☐ **Initial Request** ☐ **Change in Request**

This form should be completed by a provider who has knowledge of the enrollee's current clinical presentation and his/her treatment history. **Please provide copies of any materials that will be helpful in reviewing this request.** Submit to the Authorization Central Line **Fax: 202-721-7190** or email: **UM@hschealth.org.**

IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.

DATE OF REFERRAL:	
PROVIDER	**MEMBER**
Current Behavioral Health Provider:	**Member Name:** **Sex:** ☐**M** ☐**F**
Provider NPI #:	**Member ID:** **DOB:** **Age:** **School Grade:**
Provider Phone #: **Fax #:** **Provider Email:**	**Primary Diagnosis:**
Provider Type: (School-based, Community Based, etc.)	**Other Diagnoses:**

*****An in-home assessment will be performed by an independent licensed behavioral health professional identified by HSCSN. This licensed professional will determine whether the enrollee meets medical necessity criteria for home-based services. Upon approval, HSCSN will conduct ongoing review of home care services for medical necessity and appropriateness. *****

REASON FOR REFERRAL/PRESENTING PROBLEM

(Provider indicate specific concern which may have an impact upon the member's health and/or recovery)

PERTINENT HEALTH HISTORY – To be completed by referring provider

DSM-V Diagnoses:

Medications: Therapies:

Hospitalizations: Hospitalization for Suicidal Ideation/Attempts: PRTF:

Family Functional History:

History of Substance Abuse:

Lives with: ☐ Parent ☐ Relative ☐ Foster Parent ☐ Group ☐ Lives Alone ☐ Other (please specify):

Legal Status: ☐ Probation ☐ DYRS ☐ Foster Care ☐ CPS

History of Abuse: ☐ Verbal ☐ Sexual ☐ Physical ☐ Emotional Abuse

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OTHER PERTINENT INFORMATION (Check all that apply)

Behavioral Health ☐ Aggression ☐ Emotional Instability ☐ Extreme Impulsivity ☐ Over-agitation	**Non-Compliant Behavior** ☐ Medication Compliance ☐ Outpatient Treatment Compliance **Cognitive Limitations** ☐ Mild ☐ Moderate ☐ Severe ☐ Intellectual Disability ☐ Mild ☐ Moderate ☐ Severe ☐ Profound	**Physical Health Limitations** ☐ Please specify **Caregiver limitations** ☐ Cognitive ☐ Social ☐ Physical

Activities of Daily Living (with or without cueing): Bathing: (Check one) I ☐ M ☐ D ☐ ☐ N ☐ MM ☐ S Grooming: (Check one) I ☐ M ☐ D ☐ ☐ N ☐ MM ☐ S Dressing: (Check one) I ☐ M ☐ D ☐ ☐ N ☐ MM ☐ S Eating: (Check one) I ☐ M ☐ D ☐ ☐ N ☐ MM ☐ S Mobility-Ambulation I ☐ M ☐ D ☐ ☐ N ☐ MM ☐ S Incontinence > 3 yo Y ☐ N ☐	I= independent (able to do it on their own w/very minimal assistance) M=moderate dependence (needs minimal to moderate assistance) D=dependent (cannot perform on their own without maximal assistance) N=normal for age MM=mild/moderate limitations S=severe limitations

Impairment: Please indicate if there is an impairment in the functions below and explain:

☐ Social ☐ Emotional ☐ Attention ☐ Safety/Judgment

Signature of requesting provider: Date:

Printed Name with credentials: