Pathways, Inc.
we put people first

Children and Family Treatment and Support Services (CFTSS) Referral v3.23

Youth First/Last Name: _____ DOB: _____

Preferred Gender/Pronouns: _____ Assigned Gender: _____ Alias: _____

REQUIRED: **Medicaid CIN**: _____ **Social Security Number**: _____

Youth Address: _____

Phone Number(s) – Mobile: _____ Alternate Phone/Email: _____

Current Living Situation: ☐ Foster Care ☐ Community Residence ☐ With Parents/Legal Guardians ☐ Other

Race: ☐ Mutliracial ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Black/African American ☐ Hispanic or Latino/a ☐ Asian ☐ A Race/Ethnicity Not Listed ☐ Decline to Specify
Primary Language: _____

Mental Health/Substance Abuse Diagnosis (required): _____

DSM 5/ICD-10 Code: _____ Date of Diagnosis: _____ Diagnosed By: _____

Consent provided by: ☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Youth (18 and older)

Consenter Name (Printed) _____

Consenter Signature: _____ Date: _____

Consenter Address: _____

Consenter Phone/Email/Preferred Method of Contact: _____

Referral Source Name: _____ Title: _____

Referral Source Organization: _____

Referral Address: _____

Referral Phone Number(s): _____ Referral Email: _____

Service(s) Requested:

☐ In Home Counseling (Other Licensed Practitioner) ☐ OLP Evaluation (Other Licensed Practitioner)
☐ Intensive Supports & Treatment (Community Psychiatric Supports & Treatment)
☐ Skill Building (Psychosocial Rehabilitation)

Pathways, Inc. Staff Only: Date Referral Received: _____ Date Referral Source Contacted: _____

☐ CIN Verified in ePaces MCO details: _____

School: _____ Grade: _____ Recent Suspension(s)? ☐ No ☐ Yes: Date _____

School Behavior/Concerns: _____

_____

Developmental Diagnosis: _____ Date of Diagnosis: _____

Pediatrician/Doctor: _____ Provider Agency: _____

Is youth actively engaged in mental health counseling? ☐ No ☐ Yes

Mental Health Therapist: _____ Provider Agency: _____

Symptoms of Concern: Check all that apply within the past 60 days

☐ Depression	☐ Anxiety	☐ Phobia	☐ Danger to self	☐ Danger to others
☐ Temper tantrums	☐ Sleep disturbances	☐ Attention Deficits	☐ Physical complaints	☐ Stealing/theft
☐ Sexually harmful or coercive behavior	☐ Sexually inappropriate	☐ Alcohol/Drug use	☐ Verbally aggressive	☐ Bullying/Victim of bullying
☐ Physically aggressive	☐ Eating disturbances	☐ Negative peer interactions	☐ Hyperactive/ Impulsive	☐ Adverse experiences/Trauma
☐ Self-injury	☐ Runaway/leaving without permission	☐ Learning difficulties	☐ Problematic social behavior	☐Human trafficking/Exploitation

☐ Suicidal Ideation/Gesture: Date _____ ☐ Suicide Attempt: Date _____ ☐ Fire-Setting: Date _____

☐ Homicidal Ideation/Gesture: Date _____ ☐ Homicide Attempt: Date _____ ☐ ER/CPEP Visit: Date _____

☐ Inpatient Hospitalization: Date _____ ☐ Police Involvement: Date _____ ☐ Out of Home Placement: Date___

Details and Additional Information:

_____

_____

_____

_____

Please forward any additional clinical, educational, medical, or pertinent legal information as part of the referral/evaluation process (i.e. psychological or psychiatric reports/assessments, treatment plans, IEP's, school reports), with appropriately authorized release of information.

Please submit this referral by email to Referrals800@pathwaysforyou.org
- Or -
Youth Services Program Director; 33 Denison Parkway W, Corning, NY 14830

****Medicaid eligibility required for all services****

Eligibility Criteria for In-Home Counseling (Other Licensed Practitioner):

Criteria 1 or 2 must be met: The child/youth is assessed by the Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:

1. Corrects or improve conditions that are found through an Early Periodic Screening and Diagnostic Testing (EPSDT): screening; OR
2. Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

Eligibility Criteria for Intensive Supports & Treatment (Community Psychiatric Supports and Treatment):

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5 OR the child/youth is at risk of development of a behavioral health diagnosis; AND
2. The child/youth is expected to achieve skill restoration in one of the following areas: participation in community activities and/or positive peer support networks, personal relationships, personal safety and/or self-regulation, daily living skills, symptom management, coping strategies and effective functioning in the home, school, social or work environment.
3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND
4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License (see chart below).

Eligibility Criteria for Skill Building (Psychosocial Rehabilitation):

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM-5; AND
2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to facilitate integration of the child/youth as participant of their community and family; AND
4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License (see chart below).

All services must be recommended by one of the following Licensed Practitioners of the Healing Arts:

Licensed Master Social Worker	Licensed Psychologist	Physician
Licensed Clinical Social Worker	Physician's Assistant	Registered Professional Nurse
Licensed Mental Health Counselor	Psychiatrist	Nurse Practitioner
Licensed Creative Arts Therapist	Licensed Psychoanalyst	Licensed Marriage and Family Therapist

To Whom It May Concern:

In my clinical assessment _____(name of youth) meets Medical Necessity for Children and Family Treatment and Support Services (CFTSS) per information below:

Determination of Medical Necessity – Required for all services

☐ Yes or ☐ No (Check one). In my clinical assessment, this youth needs/would benefit from these services to (check all that apply- at least one): ☐ Likely to prevent onset of symptoms ☐ Likely to prevent worsening of symptoms

The service is needed to meet rehabilitative goals by restoring functioning level to facilitate integration of the youth as a participant of the community and family; and (check all that apply- at least one):

☐ Restore functioning level ☐ Rehabilitating functional level ☐ Facilitating participation in community, school, work, or home.

List DSM-5 or ICD-10 diagnoses:

Diagnosis Code:	Diagnosis(es):

and/or

Behavioral/Mental Health/Substance Abuse Symptoms:

*******REQUIRED- Services needed:**

☐ In-Home Counseling (OLP) ☐ Evaluation (OLP) ☐ Intensive Services & Treatment (CPST) ☐ Skill Building (PSR)

Clinician Signature (with credentials):_____ Date:_____

Clinician Name (with credentials, printed):_____ NPI Number: _____

License Number: _____

Agency / Clinic Name (if applicable, printed): _____ Agency NPI: _____

Signature of Licensed Supervisor for MHC-Permit Holder (if applicable): _____

License Number: _____ NPI Number: _____

Submit this form to Referrals800@pathwaysforyou.org

- Or -

Youth Services Program Director; 33 Denison Parkway W, Corning, NY 14830