

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REFERRAL FORM

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:
B2H WAIVER TYPE (Check one only)		REFERRAL TYPE (Check one only)
<input type="checkbox"/> B2H Serious Emotional Disturbance (SED) Waiver <input type="checkbox"/> B2H Developmental Disabilities (DD) Waiver <input type="checkbox"/> B2H Medically Fragile (MedF) Waiver		<input type="checkbox"/> Initial Referral <input type="checkbox"/> Subsequent Referral: completed if child name is on Wait List

A list of Health Care Integration Agencies was provided to the child/medical consentor. The child/medical consentor has selected the following agency:

HEALTH CARE INTEGRATION AGENCY NAME:		PHONE #:	
HEALTH CARE INTEGRATION AGENCY ADDRESS:	CITY:	STATE:	ZIP CODE:
HEALTH CARE INTEGRATION AGENCY STAFF CONTACT NAME:			

The _____ has determined that the child
 LOCAL DEPARTMENT OF SOCIAL SERVICES (LDSS) OR DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY)

identified above would benefit from the services offered by the B2H Medicaid Waiver Program. The child is Medicaid eligible. For a child in LDSS custody, we have assigned a role to their CONNECTIONS Family Services Stage.

To assist in your assessment of the child's suitability for the B2H Medicaid Waiver Program, we have included the following items:

- Authorization for Release of Information form(s), (OCFS-8001)
- B2H Medicaid Waiver Program Qualifying Diagnosis(es) and supporting documentation.
- **For a Subsequent Referral, all information from Initial Referral and Initial Application is included.**

MEDICAL CONSENTER NAME:		RELATIONSHIP TO CHILD:			
MEDICAL CONSENTER ADDRESS:	CITY:	STATE:	ZIP CODE:	PHONE #:	

LOCAL DEPARTMENT OF SOCIAL SERVICES OR DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJOY)
CONTACT INFO (Check One)

CONTACT'S NAME:		CONTACT'S SIGNATURE: X		DATE:	
CONTACT'S TITLE:			PHONE #:		
CONTACT'S ADDRESS:	CITY:	COUNTY:	STATE:	ZIP CODE:	