Community-Oriented Recovery and Empowerment Services Referral

Referral To

Date of referral _____

☐ Northeast Parent & Child Society ☐ Unlimited Potential

Referring Individual

Name _____

Agency name _____

Address _____

Phone _____ Email _____

Health Home Care Coordinator Information (if applicable)

Name _____

Agency name _____

Address _____

Phone _____ Email _____

Participant Information

Name _____ Date of birth _____

Address _____

Phone _____ Alternate phone _____

Email _____ Primary language _____

Participant Health Care Information

Managed care organization (MCO) _____ MCO Id number _____

MCO contact name _____ MCO email _____

MCO phone number _____ Medicaid CIN _____

Primary diagnosis & ICD 10 code _____ Secondary diagnosis & ICD 10 _____

Primary care physician _____ Phone _____

Address _____

Psychiatrist or therapist _____ Phone _____

Address _____

Briefly describe any known safety concerns (i.e., criminal record, history of violence, weapons in the home, sex offender, general or other concerns, etc.) _____

Referred Community-Oriented Recovery and Empowerment (CORE) Services

☐ Psychosocial Rehabilitation
☐ Psychosocial Rehabilitation: Employment Focus
☐ Psychosocial Rehabilitation: Education Focus
☐ Community Psychiatric Supports and Treatment (CPST)
☐ Family Supports & Training
☐ Empowerment Services (Peer Supports)

Indicate any services restrictions surrounding client availability _____

Referring individuals may want to include these items with the completed referral submission:

- ✓ Signed releases
- ✓ Eligibility assessment summary report (from UAS)
- ✓ LOSD or authorization number if available

CORE Agency Information

Agency _____ Contact name _____

Phone _____ Fax _____

Email _____

NORTHERNRIVERS
NORTHEAST PARENT & CHILD SOCIETY
PARSONS CHILD & FAMILY CENTER
UNLIMITED POTENTIAL

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Additional Resources

CORE Providers

Once initial contact is made with the participant, as the CORE provider, you will need to send the following information to the Health Home Care Coordinator to help inform the full plan of care:

- ✓ Initial service plan goals
- ✓ Frequency, scope, duration
- ✓ Date of initial contact
- ✓ HCBS authorization from MCO
- ✓ Medical necessity LPHA authorization
- ✓ Completed and signed individual service plan