Catholic Charities of Cortland County

CARING FOR OUR COMMUNITY ONE PERSON AT A TIME

Community Care Coordination for Children

Catholic Charities of Cortland County (CCOCC) is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible children and youth through age 21, into Community Care Coordination Services.

Children and youth must meet the following eligibility requirements to enroll:

1. Child/Youth currently has active Medicaid; **AND**
2. Child/Youth meets the New York State Department of Health eligibility criteria of
    a. Two or more chronic conditions; **OR**
    b. HIV/AIDS; **OR**
    c. Complex Trauma; **OR**
    d. Serious Emotional Disturbance; **AND**
3. Child/Youth has significant behavioral, medical or social risk factors which can be addressed through care management.

Making a Referral to Catholic Charities of Cortland County

1. Complete the following Community Referral Form. Please include as much detail as possible to aid us in eligibility verification.
2. Ensure the "Consent to Refer" section is completed.
3. Send the completed Community Referral Form to Amanda DeLee via secure e-mail, fax or mail:

    E-mail: **adelee@ccocc.org**
    Fax: (607) 756-5999
    Mail: Community Care Coordination for Children
    Catholic Charities of Cortland County
    33-35 Central Avenue
    Cortland, New York 13045

Once approved, individuals will be assigned a Care Coordinator at Catholic Charities who will conduct outreach to determine eligibility and begin the enrollment process into care coordination services. These services are voluntary and the child/youth and/or parent/guardian will be asked to consent during the outreach and engagement process.

If you have questions regarding the completion or status of this application, please contact Amanda DeLee, Program Manager for Community Care Coordination, at (607) 756-5992 ext. 132.

Catholic Charities of Cortland County (CCOCC) is a Care Management Agency, dedicated to providing services locally in collaboration with two Health Homes: Encompass Health Home and Children's Health Home of Upstate New York. Services provided by Catholic Charities will be identical, regardless of the Health Home selected.
If the child/youth/family member has a preference, please indicate it here:

☐ Prefers enrollment in Encompass Health Home

☐ Prefers enrollment in Children's Health Home of Upstate New York (CHHUNY)

☐ No preference

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Identifying Information

Date of Referral: _____

Child/Youth Name:	Date of Birth: Gender:
Current Address:	County of Residence:
	Medicaid CIN:
Phone :	Alternative Phone:
Managed Care Organization:	
Please indicate any need for language/interpretation services; specify primary spoken language if other than English:	

Is the child in Foster Care?

☐ Yes*

☐ No

☐ Unknown

Eligibility Information

☐ **Two or more Chronic Conditions** Examples include: asthma, cerebral palsy, congenital heart problems, cystic fibrosis, diabetes, sickle cell anemia, spina bifida, etc.

List Qualifying Chronic Conditions:

AND/OR

☐ **Serious Emotional Disturbance (SED) - *single qualifying condition***

SED is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis as defined by the most recent version of the DSM of Mental Health Disorders AND has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); OR
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); OR
- Social relationships (e.g. establishing and maintaining friendship; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); OR
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgement and value systems; decision-making ability; OR
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)

AND/OR

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☐ **Complex Trauma** - ***single qualifying condition***

Note: If this is the only box checked on the form, you must also complete the Complex Trauma Referral Cover Sheet and the Complex Trauma Exposure Screen; both must accompany your completed referral.

Definition of Complex Trauma:

1. The term complex trauma incorporates at least:
   a. Infants, children, or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, ***and***
   b. The wide-ranging, long-term impact of this exposure
2. The nature of the traumatic events:
   a. Often are severe and pervasive, such as abuse or profound neglect;
   b. Usually begin early in life;
   c. Can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
   d. Often occur in the context of the child's relationship with a caregiver; ***and***
   e. Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning
3. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability
4. Wide-ranging, long-term adverse effects can include impairments in:
   a. Physiological responses and related neurodevelopment;
   b. Emotional responses;
   c. Cognitive processes, including the ability to think, learn, and concentrate;
   d. Impulse control and other self-regulating behaviors;
   e. Self-image; and
   f. Relationships with others

AND/OR

☐ **HIV/AIDS** - ***single qualifying condition***

AND Appropriateness Criteria *(Check all that apply.)*

☐ **At risk for adverse event** *(i.e. death, disability, inpatient or nursing home admission, mandated preventive services or out of home placement)*

☐ **Has inadequate social/family/housing support, or serious disruption 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 has cognition issues**

☐ **Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home**

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Preventive Services Connectivity

Is the Child/Youth currently receiving preventive services?

☐ Yes; please specify provider name, if known: _____

☐ No

☐ Unknown

Child/Youth Inpatient Status:

Is the Child/Youth currently admitted to an inpatient facility?

☐ No

☐ Yes; please specify facility name: _____

Expected Discharge Date:_____

Narrative

(*Please provide any additional information that may be helpful in the assignment of the child/youth for services.)*

Preferred or Recommended Care Management Agency: **Catholic Charities of Cortland County**

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Parent Health Home Connectivity

Is the child/youth's parent or guardian currently enrolled in a Health Home program?

☐ Yes;

Current Health Home, if known: _____

Parent/Guardian's Medicaid CIN:_____

☐ No

☐ Unknown

Referral Source

Name: _____ Title: _____

Organization: _____ Relationship to child/youth: _____

Phone: _____ E-mail: _____

Consent to Refer

Name of Consenter: _____ Relationship to child/youth: _____

Phone: _____ Alternative phone: _____

Who has provided you with consent to make this referral?

Please note: consent to make this referral must be obtained from the parent, guardian, or legally authorized representative for children younger than 18 years old, except for youth who are married, parenting, and/or pregnant.

☐ Parent

☐ Guardian

☐ Legally Authorized Representative; Specify relationship to child/youth: _____

☐ Youth aged 18-21*

☐ Married Child/Youth*

☐ Parenting Youth*

☐ Pregnant Youth*

***ONLY** children/youth aged 18-21, or who are married, parenting, and/or pregnant may provide consent on their own behalf.

Signature of Consenter: _____ Date: _____