

## CORE Services Referral Form

Community Oriented Recovery & Empowerment

### CLIENT INFORMATION

Date of Referral: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Medicaid CIN #: \_\_\_\_\_ Name of Managed Care: \_\_\_\_\_

Does client have a therapist:  Yes  No HARP Status:

Therapist Name: \_\_\_\_\_  H1: HARP-Enrolled

Therapist Phone: \_\_\_\_\_  H4: HIV/SNP-Enrolled, meets NYS BH high-needs criteria

H9: meets NYS BH high-needs criteria\*

Other: \_\_\_\_\_

\* Individuals falling into this category are eligible to receive CORE Services when enrolled in a HARP or HIV/SNP. Eligible individuals with an H9 wishing to enroll in a HARP or HIV/SNP may contact NY Medicaid Choice at 1.855.789.4277 for enrollment options.

### SERVICE REQUEST

Recommended Services *(select all that apply)*

- Psychosocial Rehab (PSR)  Family Support and Training (FST)  Peer Support

How would you like this service to support?

### REFERRAL INFORMATION *(if not self referral)*

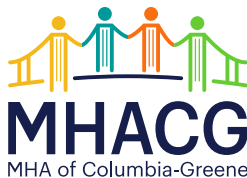
Referral Name: \_\_\_\_\_ Title: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Please email completed forms to [core@mhacg.org](mailto:core@mhacg.org) or fax to 518.828.1196



## CORE Services LPHA Recommendation

Determination of Medical Necessity

This form must be completed by a Licensed Practitioner of the Health Arts (LPHA), as defined by:

- Nurse Practitioner
- Physician
- Physician Assistant
- Psychiatric Nurse Practitioner
- Psychiatrist
- Psychologist
- Registered Professional Nurse
- Licensed Mental Health Counselor
- Licensed Creative Arts Therapist
- Licensed Marriage & Family Therapist
- Licensed Psychoanalyst
- Licensed Clinical Social Worker
- Licensed Master Social Worker, under the supervision of an LCSW, licensed psychologist, or psychiatrist employed by the agency

### HARP ELIGIBILITY

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

HARP Status:

- H1: HARP-Enrolled
- H4: HIV/SNP-Enrolled, meets NYS BH high-needs criteria
- H9: meets NYS BH high-needs criteria\*
- Other: \_\_\_\_\_

\* Individuals falling into this category are eligible to receive CORE Services when enrolled in a HARP or HIV/SNP. Eligible individuals with an H9 wishing to enroll in a HARP or HIV/SNP may contact NY Medicaid Choice at 1.855.789.4277 for enrollment options.

### RECOMMENDATION FOR SERVICES

Recommended Services (select all that apply)

- Psychosocial Rehab (PSR)
- Family Support and Training (FST)
- Peer Support

DSM-5 or ICD-10 diagnoses, if known: \_\_\_\_\_

Based on my knowledge of the individual and clinical expertise, the individual needs and/or would benefit from the above selected CORE Services for the following reasons:

- To increase capacity to better manage treatments for diagnosed illnesses
- To prevent worsening of symptoms
- To restore/rehabilitate functional level
- To increase ability to identify and advocate for effective supports
- To facilitate active participation in the individual's community, school, work, or home
- To sustain wellness and recovery-oriented life skills
- To strengthen resiliency, self-advocacy, self-efficacy and/or empowerment
- To build and strengthen natural supports, including family of choice
- To improve effective utilization of community resources

LPHA Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ NPI # \_\_\_\_\_ Date \_\_\_\_\_

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