MHACG
MHA of Columbia-Greene

# 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

Therapist Name: _____

Therapist 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.*

## 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 or fax to 518.828.1196**

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# 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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