

## Care Coordination for Children (CC4C) Referral Form

CC4C - Target Population 0-5 years			
Medicaid ID #:		Date:	
<input type="checkbox"/> Uninsured <input type="checkbox"/> Health Choice <input type="checkbox"/> Private Insurance		County child resides in:	
Patient's Name:			
Date of Birth (mm/dd/yyyy):		Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Primary language spoken in the home:		Needs Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race: <input type="checkbox"/> Asian American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific islander <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Black or African-American			
Ethnicity: <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican <input type="checkbox"/> Hispanic Other			
Parent or Guardian Information			
Parent/Guardian's Name:			
Street Address:		City:	
P.O. Box:		State:	ZIP Code:
Home Phone #: (     ) -     -		Cell Phone #: (     )     -	
Relative/Neighbor Contact Name:		Contact Phone #: (     )     -	
Employer:		Employer Phone #: (     )     -	
The family was informed of the CC4C Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referring Agency Information			
Referral Source/Agency:		Contact Person:	
Contact Phone Number:		Contact Fax Number:	
<input type="checkbox"/> Check here if you are the child's primary care provider (Medical Home).			
Priority Referrals <sup>1</sup>			
<input type="checkbox"/> The child has <b>special healthcare needs (CSHCN)</b> . Title V defines CSHCN as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who also require health and related services for a type or amount beyond that required by children generally."			
Specific concern: _____			
<input type="checkbox"/> The child is in <b>foster care</b> and does not have a medical home.			
The child is exposed to some sort of toxic stress.			
* <b>Toxic stress</b> includes, but are not limited to:			
<input type="checkbox"/> Current domestic/family violence			
<input type="checkbox"/> Caregiver unable to meet infant's health and safety needs/neglect			
<input type="checkbox"/> Parental rights have been terminated in the past			
<input type="checkbox"/> Active alcohol and/or substance abuse by caregiver			
<input type="checkbox"/> Unsafe where child lives			
<input type="checkbox"/> Homeless or living in a shelter			
<input type="checkbox"/> Parent/guardian suffers from depression or other mental condition			
<input type="checkbox"/> Unstable home			
<input type="checkbox"/> Other   Please specify: _____			
Medical Home Referral <sup>2</sup>			
<input type="checkbox"/> Check here if primary care provider (Medical Home) would like to make a direct referral for CC4C care management.			
Please state reason for referral: _____			
Notes:			
<sup>1</sup> If any of the boxes under reason/requirement for referral is checked, the child is eligible for CC4C Program and will receive a comprehensive assessment.			
<sup>2</sup> If the Medical Home provider checks the "direct referral" box, the child is automatically referred for a comprehensive assessment.			

Submit completed form to the CC4C staff at the health department in the child's county of residence.