Please Send Referrals to:

Fax: 585-328-0815

Email: homeandcommunity@villaofhope.org

VILLA OF HOPE
CORE/HCBS Referral Form

CLIENT DEMOGRAPHIC INFO: Member County_____

Member First Name: _____Middle Initial: _____

Member Last Name/s: _____

Member DOB: _____ Member Phone #: _____

Member Address: _____

Member Gender:_____ Pronouns:_____

Member Race: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ White ☐ Other
Member Ethnicity: ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Dominican ☐ Other Hispanic ☐ Not Hispanic

Insurance Provider: _____ Insurance ID:_____

Medicaid CIN #: _____

HARP Eligibility Status: ☐ H1: HARP-Enrolled ☐ H4: HIV-SNP-Enrolled, meets NYS BH high-needs criteria ☐ H9: meets NYS BH high-needs criteria (contact 1-855-789-4277 to enroll in HARP/HIV-SNP) ☐ Other:

CLIENT MEDICAL INFO:
Diagnosis Codes:

Qualifying Condition/s:

Medical Alerts/Allergies/Significant Symptoms:

_____

_____

_____

_____

_____

Please Send Referrals to:

Fax: 585-328-0815

Email: homeandcommunity@villaofhope.org

VILLA OF HOPE
CORE/HCBS Referral Form

CLIENT CONTACTS:

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Emergency Contact Relationship to Client: _____

Relevant Contacts (Physicians, Counselors, Case Managers):

_____

_____

_____

_____

Recommended Services (Select all that apply):

☐ CORE Psychosocial Rehabilitation Support ☐ CORE Psychosocial Rehabilitation—education focus

☐ CORE Psychosocial Rehabilitation—employment focus ☐ CORE Empowerment Services – Peer

☐ HCBS Ongoing Supported Employment

REFERRAL INFO:

Referral Source Name: _____ Phone #: _____

Referring Agency: _____ Referral Date:_____

Email: _____

Attestation of Non-Emergency:

☐ I understand that this service is not meant to be utilized in a crisis situation as the referral to enrollment process can be lengthy. I attest that this client is not in need of crisis services, and will refer to appropriate timely alternatives if the client is at risk of harming themselves or others.

Please Send Referrals to:

Fax: 585-328-0815

Email: homeandcommunity@villaofhope.org

VILLA OF HOPE
CORE/HCBS Referral Form

DETERMINATION OF MEDICAL NECESSITY:

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

• Physician • Psychiatrist • Psychologist • Licensed Psychoanalyst • PA • NP •PNP •RPN • LMHC • LCSW •LCAT • LMFT • LMSW (supervised by an LCSW, psychologist, or psychiatrist employed by the agency)

Note: The CORE Services designated provider will conduct an intake and engage the individual through person centered planning to determine frequency, scope, and duration of recommended services. If the referring agency does not have a licensed provider, nor can receive attestation of medical necessity from one of the client's existing providers, the Villa will make a determination of medical necessity during the intake process.

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: (Select all that apply)

☐ To increase capacity to better manage treatments for diagnosed illnesses

☐ To prevent worsening of symptoms

☐ To restore/rehabilitate functional level

☐ To increase compensatory supports

☐ To facilitate participation in the individual's community, school, work, or home

☐ To sustain recovery lifestyle

☐ 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

Diagnosis DSM-5 or ICD-10 diagnoses, if known:

_____

_____ _____ _____

Signature of LPHA Date Printed Name

NPI #:_____