Care Coordination for Children (CC4C) Referral Form

Internal Use: Date Referral Received:

CC4C - Target Population Birth to 5 Years

Child's Name:	Referral Date (mm/dd/yyyy):
Date of Birth (mm/dd/yyyy):	Gender: ☐ Female ☐ Male
Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian or White ☐ Black or African American	
Medicaid ID #:	☐ Uninsured ☐ Health Choice ☐ Private Insurance
Applied for Medicaid? ☐ Yes ☐ No	Name Private Ins. Company:

Parent or Guardian Information

Parent/Guardian's Name:		Date of Birth (mm/dd/yyyy):	
Primary Language Spoken in Home:		Needs Interpreter? ☐ Yes ☐ No	
Street Address:			
P.O. Box:	City:	Zip Code:	County:
Home Phone #:		Cell Phone #: ( ) -	
Employer:		Work Phone #: ( ) -	
Relative/Neighbor Contact Name:		Contact Phone #: ( ) -	

Referring Medical Home, Agency or Organization

Referral Organization:	Contact Person:
Contact Phone Number:	Contact Fax Number:
Contact Email:	☐ Check here if you are child's PCP/Medical Home.
Parent/Guardian Informed of Referral? ☐ Yes ☐ No	
Name of Child's Primary Care Provider, Practice Name, and Phone # (if not listed above):	

Target Populations for Referrals[1]

☐ **Child with Special Health Care Needs (CSHCN)** - Defined as a child 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 requires health and related services of a type or amount beyond that required by children generally.
Specific concern: __
If developmental concern, has child been referred for Early Intervention Services? ☐ Yes ☐ No -unknown

☐ **Child in Foster Care** who needs to be linked to a medical home.

☐ **Infant in Neonatal Intensive Care Unit (NICU)**

Child Exposed to Toxic Stress.
*__Toxic stress__ includes, but is not limited to:

- ☐ Current domestic/family violence
- ☐ Caregiver unable to meet infant's health and safety needs/neglect
- ☐ Parent(s) has history of parental rights termination
- ☐ Active alcohol and/or substance abuse by caregiver
- ☐ Unstable home
- ☐ Unsafe where child lives
- ☐ Parent/guardian suffers from depression or other mental health condition
- ☐ Homeless or living in a shelter
- ☐ Other Please specify: _____

Medical Home Referral[2]

☐ Check here if primary care provider (listed above) would like to make a direct referral for CC4C care management.
Specify reason for referral if not indicated above: _____

Notes:

[1] If any of the boxes under "Target Populations for Referral" is checked, the child is eligible for CC4C Program and will receive a comprehensive health assessment.

[2] If the Medical Home provider checks the "direct referral" box, the child is automatically referred for CC4C care management. The CC4C care manager may contact the Medical Home to clarify the need, as appropriate.

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