pennsylvania
DEPARTMENT OF HUMAN SERVICES

Complex Case Referral Form

After all efforts are exhausted to coordinate care for the child/youth at the county level and no solution is identified, please complete the following referral and submit to the Complex Case Resource Acct (RA-PWCMPLXCASEREFS@pa.gov).

☐ **Regional Complex Planning Referral** ☐ **DHS Complex Case Planning Team Referral**

CHILD/YOUTH'S NAME (LAST, FIRST, MI):	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY #:	MAID:

IF THE CHILD/YOUTH IS CURRENTLY IN OUT-OF-HOME CARE, PROVIDER NAME AND ADDRESS:

PARENT/CAREGIVER(S) NAME (LAST, FIRST), EMAIL ADDRESS, AND PHONE NUMBER:

COUNTY OF RESIDENCE:	HOME COUNTY:

AGENCIES INVOLVED:

REASON FOR REFERRAL (INCLUDE FULL SUMMARY AS ADDITIONAL ATTACHMENT):

- ☐ The resolution involves a clinically appropriate solution that requires support from multiple program offices or agencies.
- ☐ The funding solution comes from multiple sources; which may include external entities.
- ☐ The case involves complexities that render them unresolvable through the established county or regional office's processes.
- ☐ The child/youth is currently in an inappropriate placement due to an inability to identify or implement the least restrictive treatment option.
- ☐ Other: (provide explanation)

CHILD/YOUTH STRENGTHS:

SERVICES PREVIOUSLY RECEIVED AND THE EFFECTIVENESS:

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SPECIFIC NEEDS/SERVICES CURRENTLY IDENTIFIED AND RECOMMENDED, INCLUDING SPECIFIC MENTAL AND BEHAVIORAL HEALTH RECOMMENDATIONS (ATTACH ALL SUPPORTING ASSESSMENTS, SCREENINGS, AND EVALUATIONS):

Recommendation	Source of Recommendation	Approvals and/or medical necessity determination obtained?	Is the recommended support/service being received?
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

If a congregate care setting is recommended, has the following occurred:

- ☐ All possible supports have been provided to the child/youth and family to maintain the child/youth in their family home.
- ☐ The child/youth has been offered all medically necessary services they are eligible for pursuant to EPSDT.
- ☐ Less restrictive settings have been tried and no family-based setting is able to meet the child/youth's needs, including the use of Home and Community Based Medicaid Waivers to facilitate community-based settings.
- ☐ The specific needs of the child/youth that require a congregate care setting have been identified and how specifically the proposed setting will meet those needs.
- ☐ The child/youth has had the opportunity to give input into the placement decision about his or her preferences, as age appropriate.
- ☐ The child/youth's family members have provided input on the type of placement that best suits the child/youth.
- ☐ Family visitation and contact, education, and participation in activities during the placement are included in the child/youth's plan.
- ☐ A plan for discharge and family reunification is being completed (beginning at intake and reevaluated regularly).

If any of the above boxes are checked, provide explanation:

CHALLENGES OBTAINING SERVICES:

ADDITIONAL INFORMATION (PLEASE ATTACH):

- If funding assistance is being requested, provide a list of current funding source(s), funding sources that have been explored, and the specific barrier(s) to obtaining funding from existing funding sources/systems.
- If assistance is being requested to locate appropriate community-based services that would allow a family or community-based placement (non-group setting), include a list of the services or supports that would make a community or family-based placement possible.
- If assistance is being requested with locating appropriate community or congregate care services, the county should include a list of services/placements already explored and outcomes related to those service/placement referrals, including any denial reasons received for each referral.
- Provide all child/youth and family assessments, screenings, and evaluations, including relevant historical information and traumas, Individualized Family Service Plan (IFSP), the Individualized Education Program (IEP), etc.

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Referral Contact Information:

CONTACT NAME:	REFERRAL SOURCE (AGENCY OFFICE NAME):
CONTACT PHONE:	EMAIL ADDRESS:

Completed Coordination Efforts at the County Level:

PARTICIPANTS (NAME AND AGENCY, IF APPLICABLE)	
DATE OF LAST CONTACT:	TYPE OF CONTACT:
DESCRIPTION OF COORDINATION EFFORTS, INCLUDING IF LEAD MANAGED CARE ORGANIZATION (MCO) OR FEE-FOR-SERVICE (FFS) WAS CONTACTED TO DISCUSS ALL POSSIBLE OPTIONS:	

Completed Coordination Efforts with DHS Program Offices at the Regional Level, if Referring to the DHS Complex Case Planning Team:

ODP: ☐ Yes ☐ No ☐ N/A		**OMHSAS:** ☐ Yes ☐ No ☐ N/A	
COUNTY: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:	COUNTY: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
REGIONAL FIELD OFFICE: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:	REGIONAL FIELD OFFICE: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
STATE LEVEL: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:	STATE LEVEL: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
OCYF: ☐ Yes ☐ No ☐ N/A		**OMAP:** ☐ Yes ☐ No ☐ N/A	
COUNTY: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:	CONTACT NAME:	
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
REGIONAL FIELD OFFICE: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:		
DATE OF LAST CONTACT:			
STATE LEVEL: ☐ Yes ☐ No ☐ N/A	CONTACT NAME:		
DATE OF LAST CONTACT:			

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OLTL: ☐ Yes ☐ No ☐ N/A	**OCDEL:** ☐ Yes ☐ No ☐ N/A
CONTACT NAME:	CONTACT NAME:
DATE OF LAST CONTACT:	DATE OF LAST CONTACT:

Invitees for the Regional Complex Planning Team or DHS Complex Case Planning Team Meeting(s):

Name	Agency Name, if applicable	Relationship to Child/Youth	Email Address

NOTES:

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Coverage:

Physical Health Plans	HAS CURRENTLY	APPLIED FOR
Aetna Better Health	☐	☐
AmeriHealth Caritas	☐	☐
Gateway	☐	☐
Geisinger Health Plan	☐	☐
Health Partners	☐	☐
Keystone First	☐	☐
UPMC for You	☐	☐
United Health Care	☐	☐
Fee-for-Service	☐	☐
Medicare	☐	☐

Behavioral Health Plans	HAS CURRENTLY	APPLIED FOR
Community Behavioral Health	☐	☐
Community Care Behavioral Health	☐	☐
Magellan Behavioral Health	☐	☐
PerformCare	☐	☐
Beacon Health Options of PA	☐	☐
Fee-for-Service	☐	☐
Medicare	☐	☐

Waivers	HAS CURRENTLY	APPLIED FOR
Adult Autism	☐	☐
Attendant Care & Act 150	☐	☐
Community Health Choices	☐	☐
Community Living	☐	☐
Consolidated	☐	☐
Independence	☐	☐
Infants, Toddlers & Families	☐	☐
Living Independence for the Elderly	☐	☐
OBRA	☐	☐
PA Dept. of Aging 60+ (PDA)	☐	☐
Person/Family Directed Support (P/FDS)	☐	☐

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Physical Health (PH) Diagnosis (DX):

PH DX:	
PRIMARY DX:	
SECONDARY DX:	
TERTIARY DX:	
HAS CONTACT BEEN MADE WITH PH-MCO? ☐ Yes ☐ No	PH-MCO CONTACT NAME:
PLEASE PROVIDE DETAILS:	

Behavioral Health (BH) Diagnosis (DX):

BH DX:	
PRIMARY DX:	
SECONDARY DX:	
TERTIARY DX:	
HAS CONTACT BEEN MADE WITH BH-MCO? ☐ Yes ☐ No	BH-MCO CONTACT NAME:
PLEASE PROVIDE DETAILS:	

Medications (RX):

CURRENT MEDICATIONS: