

Care Coordination Referral Form

Care coordination is administrative service defined by federal and state law and Vaya Health's contracts with NC Medicaid and the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (N.C. DMH/DD/SAS). We accept internal and external referrals for care coordination from any organization or individual (including members, caregivers, hospital discharge planners, the N.C. Division of Juvenile Justice, departments of Social Services, primary care and behavioral healthcare providers, disease management programs, utilization management programs, health information lines, etc.) using the Vaya Health Care Coordination Referral Form.

To submit your referral, please follow the instructions below. Use this form to refer both Medicaid beneficiaries and uninsured individuals who are potentially eligible for care coordination for needs related to mental health (MH), substance use disorder (SUD) and/or an intellectual or developmental disability (IDD).

STEP 1: Complete the Demographic Information Section (page 2)

The Demographic Information Section on page 2 is mandatory for all referrals. Please complete all fields and enter "N/A" if needed.

STEP 2: Select and complete ONLY the most relevant referral page

This form includes seven separate referral pages based on member needs. Select ONLY the referral page most relevant to the individual being referred and complete that page only. The categories are:

- **PAGE 3: Uninsured individual with MH, SUD or IDD**
Uninsured individual involved in the Transitions to Community Living Initiative (TCLI)
- **PAGE 4: Medicaid beneficiary receiving crisis or inpatient services**
- **PAGE 5: Medicaid beneficiary - IDD**
- **PAGE 6: Medicaid beneficiary - Child MH**
- **PAGE 7: Medicaid beneficiary - Adult MH**
Medicaid beneficiary involved in TCLI
- **PAGE 8: Medicaid beneficiary - Child or adult SUD**
- **PAGE 9: Medicaid beneficiary - Child or adult co-occurring disorders (any combination of MH/SUD/IDD)**

You may click on the name of the appropriate section at the end of page 2 to jump directly to the relevant page. You do NOT need to complete other referral pages.

STEP 3: Submit your referral to Vaya Health

You may submit a care coordination referral via secure email or fax:

- **OPTION 1:** Send a secure email to Vaya at CCAdministration@vayahealth.com. If you do not have a secure email platform, you can create one at Zixmail at www.vayahealth.com. A Zixmail account will also allow Vaya staff to communicate with you securely via email regarding member information.
- **OPTION 2:** Submit the form via fax to **828-412-4096, Attn: Care Coordination Administration.**

DEMOGRAPHIC INFORMATION

Date of referral: _____

INTERNAL REFERRALS ONLY

Referring staff member: _____ Referring department: _____

EXTERNAL REFERRALS ONLY

Referring agency/provider: _____

Agency/provider staff name: _____ Telephone: _____

Referring legal guardian name (if applicable): _____ Telephone: _____

MEMBER INFORMATION

Member name: _____ Vaya ID #: _____ Date of birth: _____

Physical address: _____

Street address
City
State
ZIP Code
County

Member legal guardian (if applicable): _____ Legal guardian telephone: _____

Is the member a Medicaid beneficiary? Yes No Medicaid county: _____ Medicaid ID #: _____

Primary contact person: _____ Primary contact telephone: _____

Additional supports who may be contacted: _____

Member disability category (check all that apply): Mental health Substance use Intellectual/developmental disability (IDD)

Medical conditions (check all that apply):

- Hypertension or heart disease *If yes, specify condition:* _____
- Skin infection *If yes, specify condition:* _____
- Obesity *If yes, specify condition:* _____
- Gastrointestinal issues *If yes, specify condition:* _____
- Asthma *If yes, specify condition:* _____
- COPD *If yes, specify condition:* _____
- Diabetes *If yes, specify condition:* _____
- Other: _____

Current medications: _____

Is the member connected with primary care? Yes No

Primary care provider: _____ Telephone: _____

Has the member ever been involved with NC START? Yes No

Choose the most relevant referral page to jump to the appropriate section (see page 1).

- Uninsured - MH/SUD/IDD and/or TCLI
- Medicaid - Adult MH and/or TCLI
- Medicaid - Crisis or inpatient services
- Medicaid - Child or adult SUD
- Medicaid - IDD
- Medicaid - Child or adult co-occurring disorders
- Medicaid - Child MH

CARE COORDINATION REFERRAL: UNINSURED INDIVIDUAL WITH MH/SUD/IDD OR TCLI

Does the member meet rapid readmission criteria?

Yes No

(Rapid readmission is defined as admitting to an inpatient facility within 30 days of a previous discharge.)

Provide further information and details regarding the member's rapid readmission events:

Is the member using substances, pregnant and not connected to Medicaid?

Yes No

Is the member involved in the Transitions to Community Living Initiative (TCLI)?

Yes No

Is the member currently under an outpatient commitment?

Yes No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination

If eligible, name of care coordinator: _____

NOT eligible for care coordination

Date referral source informed of disposition: _____

CARE COORDINATION REFERRAL: MEDICAID BENEFICIARY RECEIVING CRISIS OR INPATIENT SERVICES

Is the member currently under an outpatient commitment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the crisis service the member's first contact with the behavioral health system AND the member needs assistance continuing ongoing care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member at risk of psychiatric inpatient treatment AND <i>not</i> attending outpatient appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member discharging from an inpatient psychiatric unit, facility-based crisis or psychiatric residential treatment facility (PRTF)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination *If eligible, name of care coordinator:* _____

NOT eligible for care coordination

Date referral source informed of disposition: _____

CARE COORDINATION REFERRAL: MEDICAID BENEFICIARY – IDD

Does the member have a reported diagnosis of an intellectual and/or developmental disability (IDD)? Yes No

Is there documentation to support the diagnosis? Yes No

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Diagnosis of an IDD | <input type="checkbox"/> Prader-Willi syndrome | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Autism | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Other: _____ | | |

AND:

Did the disability occur prior to age 22 and is likely to continue indefinitely? Yes No

AND:

Does the member experience three or more functional limitations in the following areas? Yes No

- | | | |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Self-care | <input type="checkbox"/> Learning | <input type="checkbox"/> Self-direction |
| <input type="checkbox"/> Language | <input type="checkbox"/> Mobility | <input type="checkbox"/> Capacity for independent living |

OR:

Does the member have an IDD diagnosis and has been in a facility operated by the N.C. Division of Adult Correction and Juvenile Justice within the past 30 days? Yes No

Did the member receive special education classes in school? Yes No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination *If eligible, name of care coordinator:* _____

NOT eligible for care coordination

Date referral source informed of disposition: _____

CARE COORDINATION REFERRAL: MEDICAID BENEFICIARY - CHILD MH

Does the member have a current CALOCUS level of VI (in or in need of an inpatient setting, psychiatric residential treatment facility/PRTF or other secure, 24-hour setting)? Yes No

OR:

Is the member currently, or has member within the past 30 days, been in a facility operated by the N.C. Division of Adult Correction and Juvenile Justice, including youth development or juvenile detention centers, and for whom Vaya has received notification of discharge? Yes No

Is the member at imminent risk for out-of-home placement? (Note: Immediate risk does not automatically ensure care coordination eligibility.) Yes No

Is the member being referred to New Hope Treatment Centers' Crisis Stabilization and Evaluation Unit? Yes No

Is the member diagnosed with a mental health disorder? Yes (specify below) No

<input type="checkbox"/> Disorders due to a general medical condition <input type="checkbox"/> Psychotic disorders <input type="checkbox"/> Mood disorders (including bipolar disorder), anxiety disorders, dissociative disorders, factitious disorders, somatoform disorders, unspecified mental disorders <input type="checkbox"/> Sexual/gender identity disorders <input type="checkbox"/> Eating disorders, tic disorders, sleeping disorders	<input type="checkbox"/> Acute stress disorder <input type="checkbox"/> Posttraumatic Stress Disorder (PTSD) <input type="checkbox"/> Depressive disorder NOS, impulse control disorder <input type="checkbox"/> Oppositional defiant disorder <input type="checkbox"/> Reactive attachment disorder
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Is the member the *victim* of neglect and/or physical, psychological or sexual abuse of a child? Yes No

Is the member the *perpetrator* of physical, psychological or sexual abuse of a child? Yes No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination *If eligible, name of care coordinator:* _____

NOT eligible for care coordination

Date referral source informed of disposition: _____

CARE COORDINATION REFERRAL: MEDICAID BENEFICIARY – ADULT MH OR TCLI

Does the member have a current CALOCUS level of VI (in or in need of an inpatient setting, psychiatric residential treatment facility/PRTF or other secure, 24-hour setting)?

Yes No

AND:

Does the member have a diagnosis of:

Schizophrenia

Other mood disorder

Bipolar disorder

Brief psychotic disorder

Major depressive disorder

Posttraumatic stress disorder (PTSD)

Is the member involved in the Transitions to Community Living Initiative (TCLI)?

Yes No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination

If eligible, name of care coordinator: _____

NOT eligible for care coordination

Date referral source informed of disposition: _____

**CARE COORDINATION REFERRAL:
MEDICAID BENEFICIARY - CHILD/ADULT SUD**

Does the member have a substance use disorder?

Yes No

AND:

Does the member have a current ASAM PPC level of III.7 or III2-D or higher (in or in need of an inpatient, detox, PRTF or other secure, 24-hour setting)?

Yes No

Is the member pregnant?

Yes No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination

If eligible, name of care coordinator: _____

NOT eligible for care coordination

Date referral source informed of disposition: _____

**CARE COORDINATION REFERRAL:
MEDICAID BENEFICIARY – CHILD/ADULT CO-OCCURRING DISORDERS**
(Complete the applicable section only)

A. MENTAL HEALTH/SUBSTANCE USE DISORDER

Does the member have both a mental illness diagnosis and a substance use diagnosis? Yes No

AND:

Does the member have a current LOCUS/CALOCUS level of V or higher? Yes No

Is the member in medically monitored residential treatment? Yes No

(Child – level III or IV; adult – nursing home or other residential treatment with medical oversight)

OR:

Does the member have a current ASAM PPC level of III.5 or higher (residential inpatient)? Yes No

B. MENTAL HEALTH/INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITY (IDD)

Is the member dually diagnosed with a mental illness and an IDD? Yes No

AND:

Does the member have a current LOCUS/CALOCUS level of IV or higher (ACTT, methadone or Suboxone treatment)? Yes No

Does this referral involve a child with complex needs? Yes No

(The children with complex needs population includes Medicaid-eligible children between ages 5 and 21 with a developmental disability and a mental health disorder who are at risk of not being able to enter or remain in a community setting.)

C. IDD/SUBSTANCE USE

Is the member dually diagnosed with an IDD and a substance use disorder? Yes No

AND:

Does member have a current ASAM PPC level of III.3 or higher? *(Clinically managed residential detox – SACOT)* Yes No

OPTIONAL: What other pertinent details are important to know?

DISPOSITION: TO BE COMPLETED BY CARE COORDINATION STAFF

Eligible for care coordination *If eligible, name of care coordinator: _____*

NOT eligible for care coordination

Date referral source informed of disposition: _____