VANDERHEYDEN
Giving new life to youth, adults and families

MORE THAN 185 YEARS

FAMILY FOCUSED • TRAUMA INFORMED • COMMUNITY BASED

REFERRAL FOR CHILDREN and FAMILIES TREATMENT SUPPORT SERVICES (CFTSS)

Vanderheyden, is accepting referrals from the community for children who may benefit from the new NYS Children and Family Treatment Support Services (CFTSS.) Children and youth who are covered by Medicaid and have mental health and/or substance use needs can get CFTSS. CFTSS Services are intended to support and stabilize a child in the community. Services can be delivered in their natural environment including, home, school or other community setting. **Services must be recommended and signed by a Licensed practitioner of the Healing Arts (LPHA)**

Current Available Services include:

1. **Other Licensed Practitioner (OLP):** Assessments for mental health and/or substance use needs, identifying strengths and abilities through individual and group therapies, individual, group or family therapy where most comfortable.
2. **Community Psychiatric Supports and Treatment (CPST):** CPST are goal directed supports and solution focused counseling services intended to address challenges associated with mental health needs and to achieve goals set forth in a child's treatment plan
3. **Psychosocial Rehabilitation (PSR):** PSR services are hands-on support interventions intended to teach skills and restore and rehabilitate a child's social, interpersonal, and community functioning
4. **Family Peer Support Services (FPSS):** FPSS are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community.
5. **Youth Peer Support and Training (YPST):** YPST services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services.

To Make A Referral:

This form allows a LPHA to complete a referral and medical necessity in the same place while obtaining consents to treat. In order for the referral to be complete, the LPHA must sign and attest to medical necessity that determines the need for CFTSS services for the child and their family.

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Children Family Treatment Support Services (CFTSS) Referral and Medical Necessity

Child's Information:

Date of Referral:		**Date of Birth:**		**Gender:**	
Child's Name (Last, First, M.I.):					
Address:					
Phone Number:		**SSN:**		**Primary Language:**	

Parent/Legal Guardian Information:

Parent/Guardian's Name (Last, First, M.I.)			
Address:		**Phone Number:**	

Referral Source Information:

Name:		**Agency:**	
Email:		**Phone Number:**	

Insurance Information:

Managed Care Organization:		**Medicaid CIN#**	

Behavioral Health Information: (A MH/SUD diagnosis is only required for a recommendation of PSR)

Diagnosis Order:	**Diagnosis Category**	**Diagnosis/Symptoms of Mental Illness or Substance Use**	**ICD 10 Code**
Primary:			
Secondary:			
Other:			

Areas of Functioning:

Check	**Domain:**	**Description of Impairment**
	Self-Direction/Self Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

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Recommended Services and Service Frequency:

Service Category	Service Type	Recommended?	# of days/week
Other Licensed Practitioner:	Licensed Evaluation (Assessment)		
	Psychotherapy (Individual, Family, Group)		
	Crisis Intervention		
Community Psychiatric Support Services:	Intensive Interventions (Individual and Family Counseling)		
	Crisis Avoidance		
	Intermediate Term Crisis Management		
	Rehabilitative Psychoeducation Services		
	Strength Based Service Planning		
	Rehabilitative Supports		
Psychosocial Rehabilitation:	Personal and Community Competence		
	Social and Interpersonal Skills		
	Daily Living Skills		
	Community Integration		
Family Peer Support Services:	Engagement, Bridging, Transition Support		
	Self-Advocacy, Self-Efficacy, Empowerment		
	Parent Skill Development		
	Community Connections and Natural Supports		
Youth Peer Support and Training:	Skill Building		
	Coaching		
	Engagement, Bridging, Transition Support		
	Self-Advocacy, Self-Efficacy, Empowerment		
	Community Connections and Natural Supports		

Reason for Recommendation:

****By signing below, I am attesting medical necessity and recommending the above-named individual for Children Family Treatment Support Services.**

_____ _____

LPHA Signature: **Printed Name:**

_____ _____ _____

NPI # **License #** **Date**

_____ _____

Email **Phone Number**

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Consent to Refer: Verbal consent to make this referral must be obtained from the parent/guardian/legally authorized representative for children up until the age of 18. For children/youth ages 18-21 or that are married, a parent or pregnant may consent on their own behalf. **Who has provided you with the consent to make this referral to Vanderheyden?**

Parent:		**Guardian:**		**Legally Authorized Representative:**		**Child/Youth:**	

There are a number of providers available for Children and Family Treatment Support Services. You have the right to select a provider that you feel will work best with you and your family. Select the provider below. Please initial next to the provider you select.

	Vanderheyden
	St. Catherine's Center for Children
	Berkshire Farm Center and Services for Youth
	Cayuga Home For Children DBA Inc., Cayuga Centers
	La Salle School
	Northeast Parent & Child Society Inc
	St. Anne's Institute

Consent to obtain and release information:

I authorize_____ (Referral Source) to release and/or receive the following information concerning my child:

	Diagnostic Evaluation Results		**Treatment Summary**		**Medication Management Records**
	Treatment Plan		**Progress Notes**		**Other:**
	Educational Records		**Safety Plan/Crisis Plans**		

The above information is only to be release to, and/or received from the following party:
Vanderheyden
CFTSS Program
1801 6th Avenue Suite 102
Troy, NY 12180

Other Authorized Parties (who can release and receive information. Please note and initial for each authorized party if they can release and receive information):

_____ Release Receive
_____ Release Receive
_____ Release Receive
_____ Release Receive
_____ Release Receive
_____ Release Receive
_____ Release Receive

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This authorization shall remain in effect until _____, or 1 year from service start date, at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I hereby release the parties named above from any liabilities for release of this information.

_____ _____

Print Name: Signature:

_____ _____

Relationship to youth: Date: