



Complex Case Referral Form

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

CHILD/YOUTH'S NAME (LAST, FIRST, MI):	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY #:	MAID:
PARENT/CAREGIVER NAME (LAST, FIRST), EMAIL ADDRESS, AND PHONE NUMBER:			
COUNTY OF RESIDENCE:		HOME COUNTY:	
AGENCIES INVOLVED:			
REASON FOR REFERRAL (INCLUDE FULL SUMMARY AS ADDITIONAL ATTACHMENT):			
<input type="checkbox"/> The resolution involves a clinically appropriate solution that requires support from multiple program offices or agencies. <input type="checkbox"/> The funding solution comes from multiple sources; which may include external entities. <input type="checkbox"/> The case involves complexities that render them unresolvable through the established county or regional office's processes. <input type="checkbox"/> The child/youth is currently in an inappropriate placement due to an inability to identify or implement the least restrictive treatment option. <input type="checkbox"/> Other: (provide explanation)			
SERVICES PREVIOUSLY RECEIVED AND THE EFFECTIVENESS:			
SPECIFIC NEEDS CURRENTLY IDENTIFIED:			
CHALLENGES OBTAINING SERVICES:			



Referral Contact Information:

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

Completed Coordination Efforts at the County Level:

PARTICIPANTS (NAME, EMAIL ADDRESS, PHONE NUMBER)	
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:

ODP: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		OMHSAS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
COUNTY: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:	COUNTY: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
REGIONAL FIELD OFFICE: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:	REGIONAL FIELD OFFICE: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
STATE LEVEL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:	STATE LEVEL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
OCYF: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		OMAP: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
COUNTY: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:	CONTACT NAME:	
DATE OF LAST CONTACT:		DATE OF LAST CONTACT:	
REGIONAL FIELD OFFICE: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:		
DATE OF LAST CONTACT:			
STATE LEVEL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	CONTACT NAME:		
DATE OF LAST CONTACT:			



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OLTL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	OCDEL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
CONTACT NAME:	CONTACT NAME:
DATE OF LAST CONTACT:	DATE OF LAST CONTACT:

NOTES:

Coverage:

Physical Health Plans			Behavioral Health Plans		
	HAS CURRENTLY	APPLIED FOR		HAS CURRENTLY	APPLIED FOR
Aetna Better Health	<input type="checkbox"/>	<input type="checkbox"/>	Community Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>
AmeriHealth Caritas	<input type="checkbox"/>	<input type="checkbox"/>	Community Care Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>
Gateway	<input type="checkbox"/>	<input type="checkbox"/>	Magellan Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>
Geisinger Health Plan	<input type="checkbox"/>	<input type="checkbox"/>	PerformCare	<input type="checkbox"/>	<input type="checkbox"/>
Health Partners	<input type="checkbox"/>	<input type="checkbox"/>	Beacon Health Options of PA	<input type="checkbox"/>	<input type="checkbox"/>
Keystone First	<input type="checkbox"/>	<input type="checkbox"/>	Fee-for-Service	<input type="checkbox"/>	<input type="checkbox"/>
UPMC for You	<input type="checkbox"/>	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	<input type="checkbox"/>
United Health Care	<input type="checkbox"/>	<input type="checkbox"/>			
Fee-for-Service	<input type="checkbox"/>	<input type="checkbox"/>			
Medicare	<input type="checkbox"/>	<input type="checkbox"/>			

Waivers		
	HAS CURRENTLY	APPLIED FOR
Adult Autism	<input type="checkbox"/>	<input type="checkbox"/>
Attendant Care & Act 150	<input type="checkbox"/>	<input type="checkbox"/>
Community Health Choices	<input type="checkbox"/>	<input type="checkbox"/>
Community Living	<input type="checkbox"/>	<input type="checkbox"/>
Consolidated	<input type="checkbox"/>	<input type="checkbox"/>
Independence	<input type="checkbox"/>	<input type="checkbox"/>
Infants, Toddlers & Families	<input type="checkbox"/>	<input type="checkbox"/>
Living Independence for the Elderly	<input type="checkbox"/>	<input type="checkbox"/>
OBRA	<input type="checkbox"/>	<input type="checkbox"/>
PA Dept. of Aging 60+ (PDA)	<input type="checkbox"/>	<input type="checkbox"/>
P/FDS	<input type="checkbox"/>	<input type="checkbox"/>



Physical Health (PH) Diagnosis (DX):

PH DX:	
PRIMARY DX:	
SECONDARY DX:	
TERTIARY DX:	
HAS CONTACT BEEN MADE WITH PH-MCO?	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?	BH-MCO CONTACT NAME:
PLEASE PROVIDE DETAILS:	

Medications (RX):

CURRENT MEDICATIONS:
