Vaya Health

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

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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: ____________________

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CARE COORDINATION REFERRAL:
MEDICAID BENEFICIARY RECEIVING CRISIS OR INPATIENT SERVICES

Question	Response
Is the member currently under an outpatient commitment?	☐ Yes ☐ No
Is the crisis service the member's first contact with the behavioral health system AND the member needs assistance continuing ongoing care?	☐ Yes ☐ No
Is the member at risk of psychiatric inpatient treatment AND *not* attending outpatient appointments?	☐ Yes ☐ No
Is the member discharging from an inpatient psychiatric unit, facility-based crisis or psychiatric residential treatment facility (PRTF)?	☐ 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: ____________________

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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

☐ Diagnosis of an IDD ☐ Prader-Willi syndrome ☐ Epilepsy
☐ Cerebral palsy ☐ Autism ☐ Spina bifida

☐ 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

☐ Self-care ☐ Learning ☐ Self-direction
☐ Language ☐ Mobility ☐ 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: ____________________

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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

- ☐ Disorders due to a general medical condition
- ☐ Psychotic disorders
- ☐ Mood disorders (including bipolar disorder), anxiety disorders, dissociative disorders, factitious disorders, somatoform disorders, unspecified mental disorders
- ☐ Sexual/gender identity disorders
- ☐ Eating disorders, tic disorders, sleeping disorders
- ☐ Acute stress disorder
- ☐ Posttraumatic Stress Disorder (PTSD)
- ☐ Depressive disorder NOS, impulse control disorder
- ☐ Oppositional defiant disorder
- ☐ Reactive attachment disorder

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: ____________________

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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
- ☐ Bipolar disorder
- ☐ Major depressive disorder
- ☐ Other mood disorder
- ☐ Brief psychotic 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: ____________________

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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: ____________________

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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: ___________________________

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