Vaya Health

Complex Care Management Referral Form

Care coordination is an administrative service provided to eligible Vaya members in accordance with applicable federal and state laws, rules and regulations and Vaya Health's contracts with NC Medicaid and the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). Complex care management (CCM) includes these required care coordination activities. Access to CCM and frequency of interventions for Medicaid members are based on eligibility, other insurance coverage available to the member and risk level presented by the member. Non-Medicaid CCM is based on eligibility, risk level and availability of funding allocated to Vaya by DMH/DD/SAS for this purpose. Medicaid is the payor of last resort, and Vaya is required to ensure that all first- and third-party sources of coverage are exhausted before accessing Medicaid or non-Medicaid public funds.

Vaya accepts internal and external CCM referrals from any organization or individual (including, but not limited to, members, caregivers, hospital discharge planners, the N.C. Division of Juvenile Justice, county Departments of Social Services, primary care and behavioral healthcare providers, disease management programs, utilization management programs, health information lines, etc.) using this Referral Form.

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

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(s)

This form includes seven separate referral categories based on member needs. Please complete the section(s)/categories most relevant to the individual being referred. The categories/sections are:

- **PAGE 3: Uninsured individual with MH, SUD or IDD and/or involved in the TCLI program**
- **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 and/or involved in TCLI**
- **PAGE 8: Medicaid beneficiary – Child or adult SUD**
- **PAGE 9: Medicaid beneficiary – Child or adult co-occurring disorders**

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, but you should submit the entire referral form.***

STEP 3: Submit your referral to Vaya Health

You may submit this referral form 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 https://providers.vayahealth.com/learning-lab/zixmail/. 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: Complex Care Management Administration.**

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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

Name: ___________________________________ **Vaya ID #:** _________________ **Date of birth:** ____________________

Physical address: ____________________________ _____________________ _____ __________ ____________________
Street address *City* *State* *ZIP Code* *County*

Legal guardian (if applicable): _______________________________________ **Legal guardian telephone:** __________________

Does the individual have Medicaid? ☐ Yes ☐ No ***Medicaid county:*** _______________ ***Medicaid ID #:*** ___________

Does the individual have CAP-C or CAP-DA? ☐ Yes ☐ No ☐ Unknown

Primary contact person: _______________________________________ **Primary contact telephone:** ____________________

Additional supports who may be contacted: ____

Population category (check all that apply): ☐ Mental health ☐ Substance use ☐ IDD

Medical conditions (check all that apply):

☐ Hypertension or heart disease
☐ Infection (skin infection, Hepatitis C, HIV, etc.)
☐ Obesity
☐ Gastrointestinal issues (liver, ulcer, etc.)
☐ Asthma
☐ Assistive technology needs (hearing aids, dentures, walkers/canes/wheelchairs, monitors, adaptive communication tools, etc.)
☐ COPD
☐ Diabetes
☐ Seizure/neurological disease
☐ Cancer history
☐ Kidney disease
☐ Other: ____

Does the individual have a primary care provider? ☐ Yes ☐ No **If yes, when was his/her last appointment?** ____________

Primary care provider: ____ **Telephone:** _______________________

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

Click on the most relevant referral category to jump to the appropriate section.

- **Uninsured individual: MH/SUD/IDD and/or TCLI**
- **Individual with Medicaid: Crisis or inpatient services**
- **Individual with Medicaid: IDD**
- **Individual with Medicaid: Child MH**
- **Individual with Medicaid: Adult MH and/or TCLI**
- **Individual with Medicaid: Child or adult SUD**
- **Individual with Medicaid: Child or adult co-occurring disorders**

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COMPLEX CARE MANAGEMENT REFERRAL:

UNINSURED INDIVIDUAL WITH MH/SUD/IDD OR TCLI

(Complex care management for Non-Medicaid populations is provided within available funding.)

Question	Response
Has the individual had three or more crisis events in the previous 12 months?	☐ Yes ☐ No
Does the individual meet rapid readmission criteria? (*Rapid readmission is defined as admitting to an inpatient facility within 30 days of a previous discharge.)*	☐ Yes ☐ No
Is the individual being discharged from a state facility, State Developmental Center or Neuro-Medical Treatment Center? *(Examples of state facilities are Broughton State Hospital and JFK ADATC)*	☐ Yes ☐ No
Is the individual currently under an outpatient commitment?	☐ Yes ☐ No
Is the individual using substances and pregnant?	☐ Yes ☐ No
Is the individual involved in the Transitions to Community Living Initiative (TCLI)?	☐ Yes ☐ No

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ________________________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: __________________________

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COMPLEX CARE MANAGEMENT REFERRAL:
INDIVIDUAL WITH MEDICAID RECEIVING CRISIS OR INPATIENT SERVICES

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

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ________________________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: __________________________

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COMPLEX CARE MANAGEMENT REFERRAL:
INDIVIDUAL WITH MEDICAID – IDD

Does the individual have a reported diagnosis of an intellectual and/or developmental disability (IDD)? *(If yes, please specify)* ☐ Diagnosis of an IDD ☐ Prader-Willi syndrome ☐ Epilepsy ☐ Cerebral palsy ☐ Autism ☐ Spina bifida ☐ Other: ____________________		☐ Yes ☐ No
Is there documentation to support the diagnosis? *(Documentation may include a psychological evaluation, school records, etc.)*		☐ Yes ☐ No
Did, or does, the individual receive special education classes in school?		☐ Yes ☐ No
AND, does the individual meet both the following criteria (A and B)?	**A. Did the diagnosis occur prior to age 22 and is likely to continue indefinitely?**	☐ Yes ☐ No
	B. Does the individual experience three or more functional limitations (i.e., a substantial impairment in the ability to function in the means or extent) in the following areas? ☐ Self-care ☐ Learning ☐ Self-direction ☐ Language ☐ Mobility ☐ Capacity for independent living	☐ Yes ☐ No
OR,	**Does the individual 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

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ____________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: ____________________

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COMPLEX CARE MANAGEMENT REFERRAL:
INDIVIDUAL WITH MEDICAID – CHILD MH

CALOCUS – Child & Adolescent Level of Care Utilization System (ages 0 to 17) *is an assessment and placement instrument developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child & Adolescent Psychiatry (AACPA). It is not intended to be a diagnostic tool, but rather an instrument to assist in the appropriate placement into a service (or Level of Care).*

Does the individual meet both the following criteria (A and B)?	**A. Does the individual have a current CALOCUS level of VI?** *CALOCUS Level of VI is Medically Managed Residential Services (secure, 24-hour program). Examples may include Psychiatric Residential Treatment Facility or Inpatient MH/SU Intensive Treatment.*	☐ Yes ☐ No
	B. Is the individual diagnosed with a mental health disorder? *(If yes, please specify)* ☐ MH disorders due to a physiological condition ☐ Psychotic disorders ☐ Mood (affective) disorders (including bipolar I/II disorder) ☐ Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders ☐ Behavioral syndromes associated with physiological disturbances and physical factors ☐ Sexual functioning disorders ☐ Impulse control disorder ☐ Oppositional defiant disorder ☐ Reactive attachment disorder ☐ Other behavioral/emotional disorders ☐ Eating disorders, tic disorders or sleeping disorders ☐ Gender identity disorders ☐ Paraphilias ☐ Child psychological abuse (suspicion, confirmed) ☐ Child neglect, sexual abuse, physical abuse (suspicion, confirmed)	☐ Yes ☐ No
OR,	**Is the individual with an MH or SUD diagnosis currently, or within the past 30 calendar days, been in a facility including a Youth Development Center/Youth Detention Center operated by the DJJ or DOC, inpatient hospital setting, Cumberland Hospital, Psychiatric Residential Treatment Facility (PRTF) or therapeutic group home for whom Vaya has received notification of discharge?**	☐ Yes ☐ No
Is the individual at imminent risk for out-of-home placement? *(Note: Immediate risk does not automatically ensure complex care management eligibility.)*		☐ Yes ☐ No

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ______________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: ______________________

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COMPLEX CARE MANAGEMENT REFERRAL:
INDIVIDUAL WITH MEDICAID – ADULT MH OR TCLI

LOCUS – Level of Care Utilization System (18 years and older) *is an assessment and placement instrument developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child & Adolescent Psychiatry (AACPA). It is not intended to be a diagnostic tool, but rather an instrument to assist in the appropriate placement into a service (or Level of Care).*

Does the individual meet both the following criteria (A and B)?	**A. Does the member have a current LOCUS level of VI?** *LOCUS Level of VI is Medically Managed Residential Services. Examples may include Medically Monitored Community Residential Treatment, Inpatient Hospital, Inpatient Intensive Treatment and Medically Managed Detox.*	☐ Yes ☐ No
	B. Does the individual have one of the following diagnoses? *(If yes, please specify)* ☐ Schizophrenia, schizoaffective ☐ Bipolar disorder ☐ Major depressive disorder, persistent mood disorder ☐ Other mood disorder ☐ Unspecified psychotic disorder ☐ Posttraumatic stress disorder (PTSD)	☐ Yes ☐ No
Is the individual involved in the Transitions to Community Living Initiative (TCLI)?		☐ Yes ☐ No

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ______________________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: ________________________

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COMPLEX CARE MANAGEMENT REFERRAL:
INDIVIDUAL WITH MEDICAID – CHILD/ADULT SUD

ASAM (American Society of Addiction Medicine) *criteria are most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.*

Does the individual meet both the following criteria (A and B)?	**A. Does the individual have a substance use disorder?**	☐ Yes ☐ No
	B. Does the individual have a current ASAM PPC level of III.7 or III2-D, or higher? *(ASAM Level of III.7 is Inpatient Intensive Treatment)*	☐ Yes ☐ No
Is the individual using substances and pregnant? *(Note: pregnancy does not automatically ensure complex care management eligibility.)*		☐ Yes ☐ No

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ________________________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: ___________________________

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COMPLEX CARE MANAGEMENT REFERRAL:
INDIVIDUAL WITH MEDICAID – CHILD/ADULT CO-OCCURRING DISORDERS
(Complete the applicable sub-section only)

CALOCUS – Child & Adolescent Level of Care Utilization System (ages 0 to 17) is *an assessment and placement instrument developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child & Adolescent Psychiatry (AACPA). It is not intended to be a diagnostic tool, but rather an instrument to assist in the appropriate placement into a service (or Level of Care).*

LOCUS – Level of Care Utilization System (18 years and older) *is an assessment and placement instrument developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child & Adolescent Psychiatry (AACPA). It is not intended to be a diagnostic tool, but rather an instrument to assist in the appropriate placement into a service (or Level of Care).*

ASAM (American Society of Addiction Medicine) criteria *are most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.*

A. MENTAL HEALTH/SUBSTANCE USE DISORDER

Does the individual meet both the following criteria (A and B)?	**A. Does the individual have both a mental illness diagnosis and a substance use diagnosis?**	☐ Yes ☐ No
	B. Does the individual have a current LOCUS/CALOCUS level of V or higher? *(LOCUS/CALOCUS Level of V is Medically Monitored Residence-Based Services. Examples may include Child – level III or IV; adult – nursing home or other residential treatment with medical oversight.)*	☐ Yes ☐ No
OR,	**Does the member have a current ASAM PPC level of III.5 or higher?** *(ASAM Level of III.5 is Clinically Managed Residential Treatment – Extended Care.)*	☐ Yes ☐ No

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

Does the individual meet both the following criteria (A and B)?	**A. Is the individual dually diagnosed with a mental illness and an IDD?**	☐ Yes ☐ No
	B. Does the individual have a current LOCUS/CALOCUS level of IV or higher? *(LOCUS/CALOCUS Level of IV is Medically Monitored Non-Residential Services. Examples may Include ACTT, methadone or Suboxone treatment.*	☐ Yes ☐ No
Does this referral involve a child with complex needs*? **The children with complex needs population includes Medicaid-eligible children between ages 5 and 21 with an IDD and a mental health disorder who are at risk of not being able to enter or remain in a community setting.*		☐ Yes ☐ No

C. IDD/SUBSTANCE USE

Does the individual meet both the following criteria (A and B)?	**A. Is the individual dually diagnosed with an IDD and a substance use disorder?**	☐ Yes ☐ No
	B. Does the individual have a current ASAM PPC level of III.3 or higher? *(ASAM Level of III.3 is a Clinically Managed Population-Specific High-Intensity Residential Services. Examples include is Residential levels III and IV or SU Therapeutic Communities.)*	☐ Yes ☐ No

OPTIONAL: Provide additional details about your answers to the above questions or other information that is important to know about the individual for the purposes of this referral.

DISPOSITION: TO BE COMPLETED BY COMPLEX CARE MANAGEMENT STAFF

☐ **Eligible for complex care management** ***If eligible, name of care manager:*** ____________________________________

☐ **NOT eligible for complex care management**

Date referral source informed of disposition: ____________________________

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