

**FORWARDHEALTH
CHILD CARE COORDINATION REFERRAL**

INSTRUCTIONS: Type or print clearly. Child care coordination (CCC) service providers use referrals to give members current information about available providers, community resources, and programs to help connect the member to services they need that were identified in the member's care plan. Providers can use this optional form for record-keeping and for sharing information with the member. For more information, refer to the Guidelines and Performance Measurements topic (#978) and the Ongoing Care Coordination and Monitoring topic (#990) of the ForwardHealth Online Handbook at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx>.

The Authorization section of this form does not replace the need for a consent document to release member information.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Date of Birth – Member

3. Member Medicaid ID Number

4. Phone Number – Member

5. Date of Referral

6. Address – Member (Street, City, State, and Zip Code)

SECTION II – REFERRAL INFORMATION

7. Name – Provider Being Referred To

8. Phone Number – Provider Being Referred To

9. Address – Provider Being Referred To (Street, City, State, and Zip Code)

10. Name – Referring CCC Service Provider

11. Name – Referring CCC Service Care Coordinator

12. Phone Number – Referring CCC Service Care Coordinator

13. Address – Referring CCC Service Care Coordinator (Street, City, State, and Zip Code)

14. Reason for Referral

SECTION III – AUTHORIZATION

15. I, _____ (Member Name), give my permission to _____ (Name of Referring Provider) to release this information to _____ (Name of Provider Being Referred To). My providers will use this information to connect me to resources and services that can help me manage my health care and social service needs.

16. **SIGNATURE** – Member / Parent or Guardian

17. Date Signed – Member / Parent or Guardian

SECTION IV – RECORD REFERRAL ACTIVITIES

18. Reply From Provider Being Referred To (Summary of Referral Findings, Diagnoses, Recommendations, Comments, or Provider Follow-up if Needed)

19. The referring provider must certify the following:

- The member understands the reason and need for referral.
- The member has been informed of all available options for obtaining the needed service.
- Any costs or limitations involved have been explained.
- The member has been helped in learning how to access the referred service, including when and how to contact the referred provider using the contact name, phone number, and address.
- Follow-up with the service agency, including appropriate advocacy on behalf of the member to make sure that services are provided, has been completed or scheduled.

20. **SIGNATURE** – Referring Care Coordinator

21. Date Signed – Referring Care Coordinator

22. Name – Referring CCC Service Provider (Print)

23. Name – Referring Care Coordinator (Print)
