Potentially Medically Frail Referral

To: CareSource

Attn: Medically Frail Care Manager

Fax: **937-487-0131**

Date: _____

Patient Name: _____ Patient RID #: _____

Patient DOB: _____

CareSource Confirmed Eligibility Date: _____

The patient listed above is a member of CareSource Healthy Indiana Plan (HIP). Our records indicate the member may have a complex behavioral health condition, which may qualify him/her for HIP State Plan Medically Frail benefits.

We are requesting an assessment to determine medically frail status. Enclosed you will find the completed Behavioral Health Condition Questionnaire, supporting patient records (including treatment plan and prognosis), and a copy of the release of information authorization signed by the patient. Please let us know if additional information is required to complete the medically frail determination.

Community Mental Health Center: _____

Contact Person: _____

Phone: _____ Fax: _____

Behavioral Health Condition Questionnaire

1. Please select from below or write in any behavioral health conditions applicable to the patient: Major depression, schizophrenia, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, substance use disorder* Other:	
2. Age at onset:	
3. Severity:	
4. Other behavioral or physical conditions:	
5. Present psychological or psychiatric treatment or counseling:	
6. Previous history of psychological or psychiatric treatment or counseling:	
7. Is patient able to work?	
8. Prognosis:	
9. Symptoms:	
10. Other relevant information:	

*Member consent for release of substance abuse records must be specified in release of information authorization (42 CFR Part 2).

Supporting documentation included:

___ Intake assessment (initial evaluation)

___ Intake assessment (medical)

___ History & physical

___ Psychosocial (if not included in initial evaluation)

Provider Signature: _____

Date: _____