Potentially Medically Frail Referral

To: CareSource

Attn: Medically Frail Care Manager

Fax: **937-487-0131**

Date: _____

Patient Name: _____ Patient RID #: _____

Patient DOB: _____ Patient Phone #: _____

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:	

Consent to Share Health Information

CareSource believes it is important that you agree to share your health information. This information is shared to handle your care and treatment or to help with benefits. It will be shared with your past, current, and future treating providers. It also will be shared with the Health Information Exchanges (HIE). An HIE lets providers view health information that CareSource has about members. You have the right to ask for a list of everyone who was given your health information by CareSource.

☐ Check this box if you want your health information to be shared with past, current, and future treating providers. The information will be shared for treatment, to manage your care and to help with benefits. Your health information to be shared will include sensitive health information, including treatment for substance use and HIV/AIDS.

Or –

☐ Check this box if you **do not want** your health information to be shared with past, current, and future treating providers. The information will not be shared for treatment, to manage

your care or to help with benefits. None of your health information will be shared with your providers, with these exceptions:

- Due to state requirements we must follow, your Primary Medical Provider (PMP) will receive a report that includes physical and behavioral health treatment information you may have received. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.
- Due to other requirements we must follow, your health information will be shared with the HIE. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.

If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as they could if you did approve sharing.

Supporting documentation included:

___ Intake assessment (initial evaluation)

___ Intake assessment (medical)

___ History & physical

___ Psychosocial (if not included in initial evaluation)

Provider Signature: _____

Date: _____

Member Signature: _____

Date: _____