|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CMARC - Target Population Birth to 5 Years** | | | | |
| Child’s Name: | | Referral Date (mm/dd/yyyy): | | |
| Date of Birth (mm/dd/yyyy): | | Gender:  Female  Male | | |
| Race:  Asian  American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander  Caucasian or White  Black or African American | | | | |
| Medicaid ID #: | | Uninsured  Health Choice  Private Insurance | | |
| Applied for Medicaid?  Yes  No | | Name Private Ins. Company: | | |
| **Parent or Guardian Information** | | | | |
| Parent/Guardian’s Name: | | Date of Birth (mm/dd/yyyy): | | |
| Primary Language Spoken in Home: | | | Needs Interpreter?  Yes  No | |
| Street Address: | | | | |
| P.O. Box: | City: | Zip Code: | | County: |
| Home Phone #: (     )-      - | | Cell Phone #: (     )      - | | |
| Employer: | | Work Phone #: (     )      - | | |
| Relative/Neighbor Contact Name: | | Contact Phone #: (     )      - | | |
| **Referring Medical Home, Agency or Organization** | | | | |
| Referral Organization: | | Contact Person: | | |
| Contact Phone Number: | | Contact Fax Number: | | |
| Contact Email: | | Check here if you are child’s PCP/Medical Home. | | |
| Parent/Guardian Informed of Referral?  Yes  No | | |  | |
| Name of Child’s Primary Care Provider, Practice Name, and Phone # (if not listed above): | | | | |
| **Target Populations for Referrals1** | | | | |
| **Child with Special Health Care Needs (CSHCN)** - Defined as a child at increased risk for a chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who requires health and related services of a type or amount beyond that required by children generally.  Specific concern:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If developmental concern, has child been referred for Early Intervention Services?  Yes  No  **Child in Foster Care**  **Infant in Neonatal Intensive Care Unit (NICU)**  **Child Exposed to Toxic Stress.**  \***Toxic stress** includes, but is not limited to:  Current domestic/family violence  Caregiver unable to meet infant’s health and safety needs/neglect  Parent(s) has history of parental rights termination   Parental/caregiver substance abuse, neonatal exposure to substances  CPS Plan of Safe Care referral for “Substance Affected Infant” **(Complete section “Infant Plan of Safe Care”)**  Unstable home  Unsafe where child lives  Parent/guardian suffers from depression or other mental health condition  Homeless or living in a shelter  Other Please specify:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Medical Home Referral2** | | | | |
| Check here if primary care provider (listed above) would like to make a direct referral for CMARC care management.  Specify reason for referral if not indicated above:      \_\_ | | | | |
| Notes:**1**If any of the boxes under “Target Populations for Referral” is checked, the child is eligible for CMARC Program and will receive a comprehensive health assessment.**2** If the Medical Home provider checks the “direct referral” box, the child is automatically referred for CMARC care management. The CMARC care manager may contact the Medical Home to clarify the need, as appropriate. | | | | |

DSS- 1404 (Rev. 07/2017) **Please submit Guilford County completed referrals to: Deborah Goddard, CMARC Supervisor**

**Fax to 336-641-8016** or *mail* **to 501 E. Green St., High Point NC 27260,** *or* **email** [**dgoddar@guilfordcountync.gov**](mailto:dgoddar@guilfordcountync.gov)