Magellan Health Services/DDD CCCT Referral Form
Community Collaborative Care Teams
AHCCCS Medical Policy Manual Chapter 500/Policy 570

Date: _____

This form is designed to provide information for the CCCT referral process. The CCCT Referral policy is designed for ALTCS/DDD members who demonstrate inappropriate sexual behaviors and/or aggressive behaviors **only**, and who have been unresponsive to traditional ALTCS and Behavioral Health services and who have a (a) co-occurring behavioral health condition OR (b) a co-occurring physical health condition.
Any behavioral health provider or DDD Regional/District representative may refer a member for consideration to a RBHA/DDD CCCT.

DEMOGRAPHIC INFORMATION:

Member Name: _____ DOB: _____

Parent/Guardian:_____

Other Agency Contact Information: _____

_____

Cultural/Language Considerations (specify) _____

_____

HEALTH PLAN INFORMATION:

AHCCCS ID: _____ Health Plan:_____

PCP Name and Contact Information: _____

Other Insurance: Yes_____ No_____ If yes, name other Insurance: _____

_____ Medicare: Yes_____ No_____

Name of Medicare Plan & Medicare ID_____

Medicare D Yes_____ No_____ Name of Medicare D Plan_____

DME/Specialty/Dental Provider_____

Inpatient Status: _____

Recent hospitalizations (medical or behavioral)_____

CLINICAL INFORMATION:

Diagnosis:

AXIS I_____ AXIS II_____

AXIS III_____ AXIS IV_____

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GAF Score if Known_____

Medications:_____

_____

Please attach last six months of medical and psychiatric records.

Medical History: _____

_____

_____

Last Known PCP Visit/History and Physical: _____

Current Place of Residence: Home:____ DDD_____ B/H_____ Community_____

Court Ordered: Yes_____ No_____ If yes: PAD_____ GAD_____ Date: _____

Guardian: Self_____ Family member_____ Pub Fid_____ Other_____

SMI: Yes_____ No_____ ACT Team Services in Place: Yes _____ No_____

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PRESENTING ISSUES OF SEXUALLY INAPPROPRIATE AND AGGRESSIVE BEHAVIOR: Please give specific description of target behaviors that are causing member to be unable to function adequately in his or her present community setting with current services in place.

_____

_____

_____

_____

_____

_____

Recent crisis events: Yes_____ No_____ Dates: _____

ARCP/Crisis Plan: Yes_____ No_____ Date of last Crisis Plan:_____

DD/ISP: Yes_____ No _____ Date of DD/ISP _____

Person Centered Plan: Yes_____ No_____ Date of last Person Centered Plan_____

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BH PNO or Provider: _____

High Needs Case Manager: Yes_____ No_____ Name of HNCM_____

SMI Case Manager Name and Contact Information:_____

_____

DDD Support Coordinator Name and Contact Information: _____

_____

DDD Vendor Agency: _____

Functional Behavioral Assessment: Yes_____ No_____ If yes, when_____

DDD services in place_____

_____

Behavioral health services in place:_____

_____

_____

Medical services in place (e.g. DME, specialty services, oxygen, dialysis, home health, etc.):

_____

_____

RECOMMENDED FOLLOW-UP CARE AND/OR ACTIVITY:

Behavioral Health Services: _____

_____

_____

_____

_____

DDD: _____

_____

_____

_____

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Comments: _____

_____

_____

_____

Submitted by(please print):_____Date: _____

Signature: _____

Title:_____

Please complete this form and fax it to Magellan Health Services at: 1-800-424-4270

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TO BE COMPLETED BY THE MAGELLAN DD LIAISON ONLY:

DISPOSITION OUTCOME:
Date of referral receipt: _____

Referred for CCCT Yes_____ No_____ Date: _____

Date of Disposition to referral source with recommendations: _____

_____

_____