|  |  |
| --- | --- |
|  | **Primary Care Physician (PCP)**  **Referral/Authorization of ECLIPSE Services** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL TO:** | | | | | | | | |
| 1. ECLIPSE CONTRACTED PROVIDER | 2. PROVIDER SITE | | | | | | | 3. PROVIDER NUMBER |
| 4. PROVIDER ADDRESS | | | | | | | | |
| 5. ECLIPSE FACILITY/ CONTACT PERSON | | 6. TELEPHONE NUMBER | | | | | | 7. FAX NUMBER |
| **HEALTH CARE PROVIDER AUTHORIZATION OF SERVICES** | | | | | | | | |
| **Initial Referral** | **Re-Authorization for Services** | | | | **Program Discharge/Withdrawal** | | | |
| 1. PHYSICIAN | 1a. PHYSICIAN SIGNATURE | | 2. EMAIL ADDRESS | | | | | 3.REFERRAL DATE |
| 4. PHYSICIAN OFFICE ADDRESS | | | | | | | | 5. TELEPHONE NUMBER |
| 6. CHILD’S NAME (FIRST – MIDDLE - LAST) GENDER: Female Male | | | | | | 7. DATE OF BIRTH | | |
| 8. PARENT/CAREGIVER(S): Birth Parent  Foster Parent  Legal Guardian | | | | 9. STATE CUSTODY?  Yes  No  OUT OF HOME PLACEMENT Yes  No | | | | |
| 10. ADDRESS (Mailing): | | | | | | 11. CELL PHONE #: | | |
| (RESIDENCE IF DIFFERENT): | | | | | | OTHER PHONE #: | | |
| CITY: | ZIP CODE: | 12. LANGUAGE: | | | | 13. RECEIVES TEXT?  Yes No | | |
| **ELIGIBILITY REQUIREMENTS:**  **Qualifies for Medicaid (required)** MCO:  Coordinated Care  Molina  CHPW  Amerigroup  **Exposure to one or more of the following risk factor(s):**  Hx of abuse/neglect  Impacted by parents’ substance abuse or mental health concerns  Parental incarceration  Fetal exposure to alcohol or drugs  Homeless / limited resources / support  Domestic violence exposure | | | | | | | | |
| **POTENTIAL GOALS FOR SERVICES:**  Support health and safety  Increase positive parenting  Increase Parent/Child Relationship  Improve self-regulation/social skills in child | | | | | | | | |
| **DEPARTMENT OF CHILD YOUTH & FAMILIES ONLY** | | | | | | | | |
| DEPARTMENT OF CHILD, YOUTH & FAMILIES ADMINISTRATOR | | | | | | | | DATE |
| AUTHORIZATION DATES:  (Should be no longer than 6 months) | BEGIN: | | | | | | END: | |

**PCP REFERRAL/AUTHORIZATION OF SERVICES INSTRUCTIONS**

This form acts as an Initial Program Referral, Re-authorization, and Discharge for ECLIPSE Program Services. ECLIPSE serves children birth to age 5 who are at risk of child abuse and neglect and may be experiencing behavioral health issues due to exposure to complex trauma.

The child’s Primary Care Physician/Provider (PCP) and/or designated staff must complete this form. The following instructions provide guidance to referent on how to complete referral/authorization of services form.

ECLIPSE Program services include:

* Strength-Based Initial Assessment and Age Appropriate Treatment Services
* Quality Early Learning Care in State Licensed Facilities that focus on Children’s Social/Emotional Wellness.
* Monthly Home Visits with family to assist them in identifying family goals and work towards reunification.

ECLIPSE Provider Staff will send progress reports every 6 months to the PCP that include(s):

* Summary of monthly home visits.
* Status of child’s progress in reference to services received to support treatment outcomes.
* Family’s participation/anticipated outcomes.
* Update on safety issues regarding safety plan (if applicable).

**REFERRAL TO SECTION**

This section is to be completed by the referent to include the following information regarding ECLIPSE Contactor and Contact Person:

1. Name of ECLIPSE Contractor
2. Name of ECLIPSE Program Site.
3. ECLIPSE Provider Number.
4. ECLIPSE Contractor Address.
5. Name of ECLIPSE Facility Contact Person.
6. Telephone Number of ECLIPSE Contact Person.
7. Fax Number of ECLIPSE Contractor

**HEALTH CARE PROVIDER AUTHORIZATION OF SERVICES SECTION**

This section is to be completed by referent to include referral type:

**Initial Authorization**:

If this is the first time referring the child to ECLIPSE Program, the purpose of the Initial Authorization is to initiate services. The referent will indicate initial authorization by checking the Initial Referral Authorization box.

**Re-Authorization**:

If a child is attending the ECLIPSE program, the purpose of the Re-Authorization is to extend enrollment and ECLIPSE Provider Services for an additional 6 months. The referent will indicate a Re-Authorization for a child by checking the Re-Authorization box after staffing the child and family progress with ECLIPSE contract staff and child’s parent/legal guardian.

**Program Discharge/Withdrawal**:

Child and Family Team will hold a staffing at least every 180 days to review each child/family case. If team decides that discharge is within the best interest of the child/family. ECLIPSE contractor will document a Program Discharge/Withdrawal by checking the identified box on the ECLIPSE PCP Authorization of Service Form. ECLIPSE contractor will email a copy to the ECLIPSE Administrator, notify all members of the service team, and complete the families discharge plan.

**PCP Referent will complete the following information section regarding PCP, Child, and Family:**

1. Name of Physician;

1. a. Physician Signature

1. Physician Email Address
2. Date of Referral
3. Address of Physician Office
4. Physician Office Telephone Number
5. Name and Gender of Child
6. Child’s Date of Birth
7. Name of Parent, Foster Parent, or Legal Guardian check box best represents relationship to child.
8. Indicate if child is in state custody by marking box yes or no. Indicate if child is in out of home placement by marking box yes or no.
9. Child and Family Mailing and Residence Address
10. Family Cell Phone Number and/or Other Phone Number to Contact Child’s Family
11. Primary Language Used in the Home

**ELIGIBILITY REQUIREMENTS**

This section is to be completed by the PCP/PCP Designee:

* Indicate if the child qualifies for Medicaid by checking the box; also; check the box next to MCO coverage for child.
* Indicate the Child’s Exposure to Risk Factor(s) by checking the box next to each risk factor present in child’s life.

**POTENTIAL GOALS FOR SERVICES**

This section is to be completed by the PCP/PCP Designee:

* Check the box next to the service goal that best identifies reason for referral and goal for child and family to work on while enrolled in ECLIPSE services.

**SECTION 3 – DEPARTMENT of CHILDREN YOUTH and FAMILIES ONLY**

This section is completed by the Department of Children Youth and Families (DCYF) Gatekeeper as the financial authorization for the program payment.

**AGENCY CONTACTS TO ASSIST EXPEDITE PCP REFERRAL FORM**

Once form is completed, the referent submits the referral to the DCYF ECLIPSE Administrator via secured email of by fax. The ECLIPSE Administrator will process the referral and send completed copy to ECLIPSE Contractor and PCP for their records. The ECLIPSE contractor will contact family to complete enrollment process with child and family.

**DCYF ECLIPSE STAFF CONTACT**

Email [Veronica.Santangelo@dcyf.wa.gov](mailto:Veronica.Santangelo@dcyf.wa.gov)

**ECLIPSE FACILITY STAFF CONTACT**

Childhaven: Catholic Charities:

Kelsey Sprague 206.957.4841 Esteban Cabrera 509-965-5575