Care Coordination Form (CCF)

The CCF is a vetted tool for documented information sharing between a home visiting agency and the primary care medical home regarding a patient. The needed parent/guardian consents that meet both the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) requirements are built into this form. This consent form authorizes the referring agency to share pertinent information with the medical home and provides consent for the medical home to share relevant patient information with the referring home visiting agency.

Section 1. Family Contact Information

Patient Name: ____ AKA______________________ Patient is (check one) ☐child ☐mother

Parent/Guardian Name (if patient is under 18): ____AKA______________________________

Street Address: ____

City: _________________________________ State: __________ Zip: _____________ County: ____________________

Patient Date of Birth: _____/_____/_____ Patient Gender: M F Race: _______________________________________

Type of Insurance Coverage: ☐ Medicaid ☐ Private Insurance Medical card # ___________________________________

Name of Previous Healthcare Provider: ____

Primary Language: __________________________ Home Phone: _____/_____-_______ Other Phone: _____/_____-_______

Alternate or Emergency Contact Person: ____ Phone: _____/_____-_______

Section 2. Reason(s) for Contact

Reason(s) for contact (Please check all that apply):

☐Family/Patient has been assigned a home visitor (see **Section 3. Referral Source Contact Information**)

☐ Suspected medical condition or previous medical diagnosis (e.g., spina bifida, Down syndrome): __________________________________

☐ Concern based on objective screening using:

- ☐ 4P's Plus
- ☐ Relationship Assessment Tool
- ☐ Edinburgh Assessment
- ☐ ASQ-3 Assessment
- ☐ ASQ-SE Assessment
- ☐Other, specify____

Other Area(s) of concern (please check all that apply):

__Motor/Physical __Cognitive __Social/Emotional __Speech __Language/Communication __Behavior __Vision

__Hearing __Adaptive/Self-help skills __Maternal Mental Health __Relationship assessment __Substance Use

Comments

____

____

____

☐ Referral made to __________________________________(name of referral source) on ______________________(date referral made)

☐ Request for patient medical information (please specify the type of information)____

____

☐ Family is aware of reason(s) for contacting the Primary Care Provider

Section 3. Referral Source Contact Information

Submission Date: _____/_____/_____

Name of Referral Source: ________________________________Name of Referral Source Agency: ____________________________________

Address: ____City: ______________________________State: ______ Zip Code: ________

Referral Source Contact Phone: _____/_____-_______ Referral Source E-mail: ____

Referral Source Agency Office Phone: _____/_____-_______ Office Fax: _____/_____-_______

Additional Contact person at Referral Source Agency: ____

Section 4: Primary Care Provider Contact Information

Name of Patient's Primary Care Provider: ____

Street Address: ____

City: ______________________________________ State: _____________ Zip Code: ___________________________

Office Phone: _____/_____-_______ Office Fax: _____/_____-_______ E-mail: ___________________________________

Contact Person at Primary Care Provider Office: ____

Section 5: Authorization to Release Information

a. Information Sharing with Primary Care Provider. The purpose of this disclosure is to share information concerning ___________________________ (print name of patient) with the patient's primary care provider. I, __________________________________(print name of patient or name of parent/guardian if the patient is under 18), give my permission for the referral source contact, ____________________________________ (print name of referral source contact), to share pertinent information about ____ (print name of patient), regarding specified reason(s) for contact under **Section 2. Reason(s) for Contact** of this form, with the primary care provider________________(print name of primary care provider). I understand that I may withdraw this consent by written request to the referral source contact, except to the extent it has already been acted upon.

b. Information Sharing with Referral Source. The purpose of this disclosure is to release information from the primary care provider about____________________(print name of patient) including name, date of birth, relevant referrals made, and relevant medical information as requested by the referral source under **Section 2. Reason(s) for Contact,** to the referral source contact. I understand that I may withdraw this consent by written request to my primary health care provider, except to the extent it has already been acted upon.

This consent allows the Referral Source to share pertinent information with the assigned primary care provider (doctor) and treating doctors within the group, for care coordination. Care coordination allows the Referral Source to receive relevant medical information (as specified under Section 2. Reason(s) for Contact of this form) concerning the named patient from the assigned primary care provider (doctor) and treating doctors within the group

I certify that this Authorization to Release Information has been given freely and voluntarily. Information collected hereunder may not be re-disclosed unless the person who consented to this disclosure specifically consents to such re-disclosure and or the re-disclosure is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Patient or Parent/Legal Guardian Signature (if patient is under 18)*_____________________________________Date:_______/_______/_______

*Consent is effective for a period of 12 months from the date of patient or parent/legal guardian signature on this release.

For more information visit: http://illinoisaap.org/projects/early-childhood-development-initiatives/home-visiting/