Care Management for At-Risk Children (CMARC)
Checklist Referral Form

Internal Use: Date Referral Received:

CMARC - Target Population Birth to 5 Years	
*Child's First and Last 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 Referrals[1]

☐ **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

☐ **Infant in Neonatal intensive Care Unit (NICU)**

☐ **Other (Please Specify):** _____

Child experienced adverse childhood event: includes, but is not limited to:

- ☐ Child in foster care
- ☐ History of abuse and neglect
- ☐ Caregiver unable to meet infant's health and safety needs/neglect
- ☐ Parent(s) has history of parental rights termination
- ☐ Parental/caregiver/ household substance abuse
- ☐ CPS Plan of Safe Care referral for "Substance Affected Infant" **(Complete section "Infant Plan of Safe Care")**
- ☐ Child exposed to family/ domestic violence
- ☐ Unsafe where child lives/ environmental hazards or violence
- ☐ Incarcerated parent or caregiver
- ☐ Parent/guardian suffers from depression or other mental health condition, maternal postpartum depression
- ☐ Homeless or living in a shelter/ Unstable housing
- ☐ Other (Please Specify): _____

Medical Home Referral[2]

☐ Check here if primary care provider (listed above) would like to make a direct referral for CMARC.

Specify reason for referral if not indicated above: _____

*Required fields

Version 1 (Rev. 11/08/2019) Submit completed form to the CMARC staff at the health department in the child's county of residence.