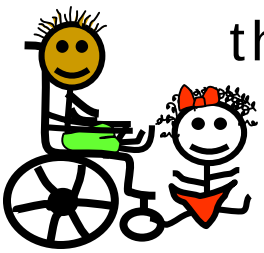
Referral Form
Attachment D

Do you know a child who is receiving Medicaid through the **STAR** Program in the Bexar County area?



1. Does this child need regular medical care that should not be stopped (such as wheelchair, ventilator, feeding tube)?

2. Does this child need or use more medical care, mental health or special education services than most others his/her age?

3. Does this child have medical or mental health problems that limit his/her daily activities compared to most others his/her age (play, school, work)?

If you answered **YES** to any of the questions above:

- Please fill out the attached referral form and mail or fax it to the address listed on the other side of this page.
- A Maximus staff person will contact the child's parent/guardian to ask a few questions about the child's health. The Maximus staff person will also give the parent more information about the BexarCare pilot.
- The child's health plan will be told if the child has special health care needs so the health plan can better meet the child's needs.

BexarCare

The State is starting a pilot in November 1999 to identify children who have special health care needs (CCSHCN) and are enrolled in the STAR Program in the Bexar County area. The goal of the pilot is to try to find these children as soon as possible and tell the child's STAR health plan. We hope that this will:

- help the health plans to make sure that the child gets the right health services as soon as they are needed;
- Help health plans to help their members with special needs in linking with community-based services.
- Help parents of children with special needs to know who to contact if help is needed in getting services for their children.

QUESTIONS?

Call toll-free: 1/877/847-8377

Ask for **BexarCare** Information

BexarCare

Referral Form

Bexar County Service Area
Medicaid Managed Care Pilot 1999/2000
for Children with Complex Special Health Care Needs

Referred by: _____
(Name, Organization, Phone)

Child's Name: _____

Address: _____

Phone: _____

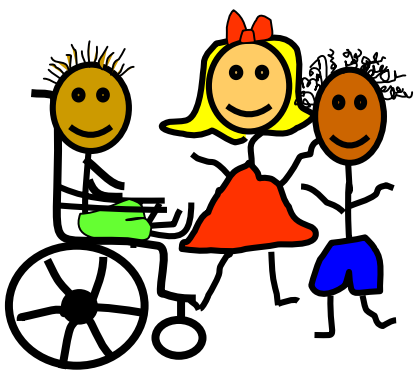
Child's Birthdate: _____

Child's Medicaid ID Number: _____

Medicaid Plan: _____

Primary Doctor (PCP): _____

Parent/Guardian Signature: _____



Please send the completed referral form to:

BexarCare Information
P.O. Box 149219
Austin, Texas 78714-9965

PHONE (toll-free): 1/877/847-8377
FAX: 1/512/821-1781

Information on this form is confidential.