DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03256 (07/2025)

STATE OF WISCONSIN

FORWARDHEALTH

CHILD CARE COORDINATION REFERRAL

INSTRUCTIONS: Type or print clearly. Child care coordination (CCC) service providers use referrals to give members current information about available providers, community resources, and programs to help connect the member and their family to services they need that were identified in the member's care plan. Providers can use this optional form for record-keeping and for sharing information with the member's family. For more information, refer to the ForwardHealth Online Handbook Ongoing Care Coordination and Monitoring topic #990 at forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx.

Note: The Authorization section of this form **does not** replace the need for a consent document to release member information.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Date of Birth – Member	3. Member Medicaid ID Number

4. Address – Member (Street, City, State, and Zip Code)

5. Name – Member's Parent, Guardian, or Caregiver (Last, First, Middle Initial)

6. Phone Number – Parent, Guardian, or Caregiver	7. Date of Referral

8. Address – Parent, Guardian, or Caregiver, If Different From Member (Street, City, State, and Zip Code)

SECTION II – REFERRAL INFORMATION

9. Name – Provider Being Referred To

10. Phone Number – Provider Being Referred To

11. Address – Provider Being Referred To (Street, City, State, and Zip Code)

12. Name – Referring CCC Service Provider Agency

13. Name – Referring CCC Service Care Coordinator

14. Phone Number – Referring CCC Service Care Coordinator

15. Email Address – Referring CCC Service Care Coordinator

16. Reason for Referral

SECTION III – AUTHORIZATION

17. I, _____ (Parent/Guardian/Caregiver Name), parent, guardian, or caregiver of _____ (Member Name), give my permission to _____ (Name of Referring Provider) to release this information to _____ (Name of Provider Being Referred To). My providers will use this information to connect me to resources and services that can help my child, me, and/or our family.

18. **SIGNATURE** – Member's Parent, Guardian, or Caregiver	19. Date Signed – Member's Parent, Guardian, or Caregiver

SECTION IV – RECORD REFERRAL ACTIVITIES

20. Reply From Provider Being Referred To (Summary of Referral Findings, Diagnoses, Recommendations, Comments, or Provider Follow-up if Needed)

21. The referring provider must certify the following:

- ❑ The member's parent or caregiver understands the reason and need for referral.
- ❑ The member's parent or caregiver has been informed of all available options for obtaining the needed service.
- ❑ Any costs or limitations involved have been explained.
- ❑ The member's parent or caregiver has been helped in learning how to access the referred service, including when and how to contact the referred provider using the contact name, phone number, and address.
- ❑ Follow-up with the service agency, including appropriate advocacy on behalf of the member and member's family to make sure that services are provided, has been completed or scheduled.

22. **SIGNATURE** – Referring Care Coordinator	23. Date Signed – Referring Care Coordinator

24. Name – Referring CCC Service Provider (Print)

25. Name – Referring Care Coordinator (Print)

Reset Form