COMPLEX BEHAVIORAL COLLABORATIVE (CBC)
INSTRUCTIONS FOR COMPLETING AND SUBMITTING REFERRAL

Referral to the Complex Behavioral Collaborative (CBC) must be done through an agency. If the referring agency is different than the agency providing community services (i.e. API, Providence Hospital, etc.), then that agency is expected to discuss and obtain the Alaska service provider's commitment to work with the CBC and the legal guardian's consent prior to submitting a referral. Participants being referred must have housing and an Alaska service provider willing to work with them with available direct care staff as appropriate.

Note: If using the online form, you must first go into "options" and select "enable" to enter information.

Complete the Complex Behavioral Collaborative Referral form.

A) Participant Information – The participant is the individual being referred to the CBC. Include their name, address, phone numbers, date of birth, Medicaid #, Waiver type (if applicable) and other insurance.
B) Population – Check to which population(s) the participant identifies.
C) Medically Stable – A participant is medically stable if their medical conditions are being successfully treated and controlled.
D) Participant Eligibility – Check all criteria that are applicable to the participant being referred. **NOTE:** In addition, participant must have housing, a community provider willing to work with them, receive services supported by the DHSS and be medically stable.
E) Housing – Please describe housing situation.
F) Referring Agency – The referring agency is the agency making the referral to the CBC. The referring agency and the Alaska service provider may be the same if the Alaska service provider is the agency making the referral to the CBC. In some instances, a hospital or other institution (i.e. API, Providence Hospital) may be referring a participant to the CBC. Enter the referring agency name, address, name of contact person, phone number, fax number and e-mail address if available.
G) Alaska Service Provider - The Alaska service provider is the agency providing services to the participant in the home/community setting. If the Alaska service provider is different than the referring agency, enter the agency name, address, name of contact, phone number, fax number and e-mail address if available.
H) Family/Guardian Information – Enter the name of the family or legal guardian for the participant and include their contact information.
I) Clinical – Answer questions 1-10 to the best of your knowledge. Include details and be specific in your answers.
J) Attachments:
    1) Release of Information – Have participant or legal guardian sign a release of information authorizing the sharing of information with the CBC and indicating participant's agreement with the CBC referral.
    2) Written summary of participant's current presentation if not detailed on referral form.
    3) Copy of the Waiver Plan of Care (if applicable)
    4) Copy of current clinical assessments (for populations MH, DD, ADRD, SA, TBI)
    5) Relevant clinical information w/in last 90 days (specific descriptions of behaviors)
    6) Current Medications
    7) Current History & Physical
    8) Diagnostic History

Submit this referral packet, including attachments, to the Division of Behavioral Health, 3601 C Street, Suite 878, Anchorage, AK 99503 to attention of Eric Talbert or Valerie Kenny. DSM: eric.talbert@hss.soa.directak.net; or valerie.kenny@hss.soa.directak.net. Submission of an incomplete referral packet will result in delays in processing the referral.

COMPLEX BEHAVIORAL
COLLABORATIVE REFERRAL FORM
Attention: Eric Talbert 907-269-3626 or Valerie Kenny
907-269-3797
3601 C Street, Suite 878
Anchorage, AK 99503
Fax #: 907-269-8166

Referral form to be completed by Referring Agency

ASSIGNED CBC Number -

Date of Referral:_____ Date Received: _____

A) Participant Information

Name:_____
Address:_____City:_____State:_____Zip:_____
Phone Number:_____ Cell Number:_____
DOB:_____ Medicaid #: _____
Waiver Type:_____ Other Insurance: _____

B) Population: (Check all that apply)

☐ DD ☐ MH ☐ ADRD ☐ TBI ☐ Substance Abuse

C) Medically Stable:

Participant is Medically Stable ☐ Yes ☐ No Explain: _____
_____

D) Participant Eligibility:

The identified participant for this project are children and adults who are cognitively impaired and demonstrate **complex behavioral** management issues. This may include individuals experiencing one or more of the following: Chronic Mental Illness, Developmental Disabilities, Alzheimer's disease and related Dementia, Traumatic Brain Injury, Chronic Alcoholism with Cognitive Impairment.

Eligible participants must meet the following criteria:

☐ Exhibit behaviors that are complex, presenting a high risk of danger to self and others without intervention.

And meet TWO out of the four criteria listed below:

☐ Demonstrate inability to function independently in the community or current living environment **beyond** what would be expected of someone with their disability.
☐ Have exhausted all other avenues of treatment available and be or at risk for out-of-state placement, psychiatric hospitalization, or moving to a higher level of care.
☐ Are high-end resource users defined as frequent utilization of multiple systems which may include emergency room services, acute psychiatric care, substance abuse programs, and/or jail.
☐ Require interventions outside the skill set of current program staff in order to ensure safety of those involved.

Complex Behavioral Collaborative
Referral Form

Participants being referred must meet all of the following: (please check all that are applicable)

- ☐ Have stable housing;
- ☐ Have an Alaska service provider and direct care staff ready, available and willing to work with the participant;
- ☐ Be eligible for or are receiving services supported by the DHSS; and,
- ☐ Be medically stable (i.e., from medical standpoint are described as stable and able to participate in the program).

E) Housing Situation:

_____
_____
_____

F) Referring Agency:

Referring Agency: _____
Address:_____City:_____State:____Zip Code:_____
Staff Contact: _____
Contact Phone Number:_____ Fax Number: _____
Email Address: _____

G) Alaska Service Provider: (Must be identified and have accepted participant for services. This is the community agency responsible for providing services under the POC).

Referring Agency: _____
Address:_____City:_____State:____Zip Code:_____
Staff Contact: _____
Contact Phone Number:_____ Fax Number: _____
Email Address: _____

H) Family/Guardian Information:

Name:_____
Address:_____City:_____State:____ Zip Code:_____
Phone Number:_____ Cell Number: _____

Complex Behavioral Collaborative
Referral Form

I) Clinical:

1) **Behaviors:** Provide a **detailed** description of **current (last 90 days)** behaviors (types, frequency, duration, patterns, what has been tried, etc.):

_____
_____
_____

2) Describe how participant's disability prevents functioning independently in their environment beyond what would be expected of someone with their disability:

_____
_____
_____

3) What resources does participant utilize e.g. emergency room, policies, systems, etc. (be specific with frequency, duration, why it's a problem)?

_____
_____
_____

4) What treatment/services is participant currently receiving? _____
_____
_____

5) Treatment History:
   a. What's worked in the past: _____
      _____
   b. What hasn't: _____
      _____
   c. Compliance: _____
      _____

6) Clients strengths: _____
_____
_____

7) Legal History: _____
_____
_____

8) Agencies currently involved: _____
_____
_____

9) What are the provider's expectations? _____
_____
_____

10) What are the family's expectations? _____

11) What is the referring agency's degree of involvement (support)? _____

12) What staff are ready and available to work with the participant? _____

13) What is the family's degree of involvement (support)? _____

J) Attachments:

The following documents must be submitted to the Alaska Complex Behavior Collaborative at the time of referral:

- ☐ Release of information
- ☐ Signed Memorandum of Agreement
- ☐ Copy of Waiver Plan of Care (if applicable)
- ☐ Copies of most current assessment (for populations (s) MH, DD, Behavioral, Substance Abuse, TBI)
- ☐ Relevant clinical information w/in last 90 days (specific description of behaviors) Current Medications
- ☐ Current History & Physical
- ☐ Diagnostic History

Submit complete Referral Packet with attachments to Division of Behavioral Health, 3601 C Street Suite 878, Anchorage, Alaska 99503, Attention Eric Talbert or Valerie Kenny or DSM to eric.talbert@hss.soa.directak.net; or valerie.kenny@hss.soa.directak.net; or fax to 907-269-8166.

Original to File
Copy to Consultant