SPECIALTY SUPPORT PROGRAM (SSP)
HAWAII STATE DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH

SSP REFERRAL FORM

ISLAND (child/youth resides):	**DATE SUBMITTED:**

CHILD/YOUTH INFORMATION

LAST NAME:	**FIRST NAME**:	**BIRTHDATE**:

GENDER	**LANGUAGE PREFERENCES**	**ETHNICITY(IES) OF CHILD/YOUTH** (list all)
☐ MALE ☐ FEMALE ☐ DECLINE ☐ OTHER:	INTERPRETER NEEDED: ☐ YES ☐ NO ☐ UNSURE If YES, please specify preferred language:	

PARENT/GUARDIAN NAME	**RELATIONSHIP** (to child/youth)	**PHONE**	**EMAIL**
PRIMARY CONTACT (list first)			

RESIDENTIAL ADDRESS (Street, City, State, Zip Code):	**HOUSELESS**: ☐ YES ☐ NO ☐ NOT KNOWN
MAILING ADDRESS if different from RESIDENTIAL (Street, City, State, Zip Code):	

PRIMARY CARE PROVIDER NAME	**PHONE**	**FAX**

HEALTH INSURANCE INFORMATION – If QUEST, specify (e.g., QUEST-HMSA)

PRIMARY INSURANCE PLAN:	**SECONDARY INSURANCE PLAN** (if applicable)**:**	☐ **NO INSURANCE**

INFORMATION OF PERSON COMPLETING FORM

NAME	**RELATIONSHIP** (to child/youth) **or NAME OF PROGRAM**	**PHONE**	**EMAIL**

MEDICAL DOCUMENTATION SENT IN, IF AVAILABLE (Fax numbers listed below)**:** ☐ YES ☐ NO

REASON FOR REFERRAL:	**SUSPECTED CONDITIONS/DIAGNOSIS(ES):**
OTHER AGENCIES INVOLVED (if applicable):	**OTHER AGENCIES REFERRED TO** (if applicable)**:**
PARENT/GUARDIAN CONSENT IS REQUIRED PRIOR TO MAKING A REFERRAL. Parent/Guardian has given consent for this referral: ☐ YES ☐ NO	**HOW DID YOU HEAR ABOUT US** (check one)**:** ☐ EARLY INTERVENTION PROGRAM ☐ PUBLIC HEALTH NURSE ☐ FAMILY/FRIEND ☐ ONLINE SEARCH/WEBSITE ☐ DOCTOR ☐ SCHOOL ☐ COMMUNITY FAIR ☐ OTHER (specify):

MAIN OFFICE: 741 SUNSET AVENUE, HONOLULU, HI 96816

O'ahu: Phone: 808-733-9055 Fax: 808-733-9068
Kaua'i: Phone: 808-241-3376 Fax: 808-241-3480
Maui County: Phone: 808-984-2130 Fax: 808-243-5202
East Hawai'i: Phone: 808-974-4288 Fax: 808-974-4285
West Hawai'i: Phone: 808-322-4882 Fax: 808-322-1504

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SSP REFERRAL FORM

SSP Office Use ONLY

SSP STAFF (who received inquiry/referral):	**SSP Staff discussed with family and assessed needs:** ☐ YES ☐ NO ☐ N/A	**CASE #**

HOW REFERRAL WAS RECEIVED: ☐ Phone ☐ Fax ☐ Email ☐ Website ☐ Other:

TYPE OF INQUIRY OR REQUEST (check all that apply)**:**
☐ General (e.g., inquiring what available) ☐ Assistance with apps/referrals ☐ Financial help ☐ Housing ☐ Medical (e.g., finding doctor, supplies) ☐ Mental Health ☐ Behavioral Health ☐ Transportation ☐ Care Coordination ☐ NI Specialty Clinics ☐ Nutrition Consultation ☐ School/DOE ☐ Skilled Services (e.g., ST/OT/PT) ☐ Childcare/Respite ☐ Other (specify):

REFERRAL STATUS

Select One: ☐ Initiate INTAKE PROCESS ☐ CLOSE REFERRAL ☐ Inquiry or Consult Only ☐ OTHER (specify):

JUSTIFICATION/EXPLANATION IF CLOSING REFERAL:

CSHNB CHIEF REVIEW OF CLOSED REFERRALS

☐ **COMPLETE** (No further action needed)

☐ **FOLLOW-UP NEEDED**

RECOMMENDATIONS/NOTES:

CSHNB CHIEF:	**DATE:**

INTAKE STATUS

Select One:
☐ ELIGIBLE/ENROLLED ☐ PROVISIONAL ENROLLMENT ☐ NOT ELIGIBLE ☐ UNABLE TO COMPLETE ELIGIBILITY DETERMINATION
☐ OTHER (specify):

NOTES:

ADMITTING DIAGNOSIS/HEALTH CONDITION(S) & ICD CODE(S) (if applicable)

ELIGIBILITY PERIOD:	**ASSIGNED WORKER:**	**CHART/FILE:** ☐ ROUTE TO WORKER ☐ MISC. FILE ☐ OTHER: