Health Homes of Upstate New York

Chautauqua County Department of Mental Hygiene - Huther Doyle Memorial Institute
Lake Shore Behavioral Health - New York Care Coordination Program - Onondaga Case Management Services

HEALTH HOMES OF UPSTATE NEW YORK – FINGER LAKES

COMMUNITY REFERRAL FOR HEALTH HOME CARE MANAGEMENT SERVICES

Health Homes of Upstate New York – Finger Lakes (HHUNY-Finger Lakes) is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible individuals into HHUNY Health Home Care Management Services. Individuals must meet all eligibility requirements to be considered for enrollment.

HHUNY Finger Lakes Health Home Care Management Services Eligibility

1. Individual currently has active Medicaid; AND;
2. Individual resides in one of the following Counties: Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, or Yates County; AND;
3. Individual meets the NYS DOH eligibility criteria of: two chronic conditions, or HIV/AIDS and the risk of developing another chronic condition or, one or more serious mental illnesses; AND;
4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.

How to Make a Referral to HHUNY

1. Complete the attached Community Referral Application Form, including as much detail as possible to allow HHUNY to verify eligibility for health home care management services.
2. Attached a signed “Consent to Disclosure of Health Information” Form
3. Send the completed Application and Consent via secure e-mail or fax, or mail to:

HHUNY Community Referral Representative
Email: tmarchese@hhuny.org
Fax: 585-613-7670
Mail: Community Referral Specialist
New York Care Coordination Program - Health Homes of Upstate New York
1099 Jay Street, Bldg. J
Rochester, NY 14611

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the person in health home care management services. Health Home services are voluntary and the individual will be asked to consent during the outreach and engagement process.

If you have questions regarding the completion or status of this application, please contact: HHUNY Community Referral Representative at 585-613-7642

HHUNY also provides Health Homes Services in the counties of Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Cortland, Erie, Madison, Onondaga, Oswego, Tompkins, and Tioga, Please contact the Community Referral Representative to make a referral for services in any of these counties.

HHUNY Health Home Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	Cell Phone:	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Eligibility Category Information – Check All that Apply
Must meet either A only or B only or two C to be eligible

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness	
	B	HIV/AIDS & the risk of developing another chronic condition	
	C	Mental Health condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

Risk Factors - Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission	
	Lack of or inadequate social/family/housing support	
	Lack of or inadequate connectivity with healthcare system	
	Non-adherence to treatments or medication(s) or difficulty managing medications	
	Recent release from incarceration	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	

Narrative

Provide any additional information that may be helpful in assignment to a care management agency:

Specify Preferred or Recommended Care Management Agency, if any:___________________________________

Contact Information for Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email:

PERMISSION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with medical treatment and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of health care services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION

1. The person whose information may be used or disclosed is:

   Name: ____.

   Date of Birth: ____.

2. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
2. This information may be disclosed to the persons or organizations listed in Attachment A.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
4. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
5. This permission expires on ____________ (date).
6. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship ____________________.)

I give permission to use and disclose my records as described in this document.

____

Signature Date

CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A

HHUNY FINGER LAKES

Health information may be disclosed for purposes of treatment to the people and organizations listed below.

- AC Center, Inc.
- Baden Street
- Beacon Health Strategies
- Catholic Charities Community Services
- Catholic Family Center
- Coordinated Care Services, Inc.
- Delphi Drug & Alcohol Services
- DePaul Community Services
- East House Corporation
- Elmira Psychiatric Center
- Epilepsy-Pralid, Inc.
- Excellus Health Plans
- Fidelis Care
- FLACRA
- Genesee County Mental Health Services
- Hillside Family of Agencies
- Huther-Doyle Memorial Institute, Inc.
- Ibero-American Action League
- John D. Kelly Behavioral Health Center
- L. Woerner dba HCR
- Lakeview Mental Health Services, Inc.
- Livingston County Mental Health Services
- Monroe County Office of Mental Health
- Monroe Plan for Medical Care
- MVP Health Care
- New York Care Coordination Program, Inc.
- New York State Office of Mental Health
- New York State Office of Alcohol and Substance Abuse Services
- Ontario County Department of Mental Health
- Orleans County Department of Mental Health
- Regional Primary Care Network/Rushville Community Health Center
- Rochester Psychiatric Center
- Rochester General Health System
- Schuyler County Community Services
- St. Joseph's Villa – Villa of Hope
- Steuben County Community Mental Health Services
- The Arc of Orleans County
- United Healthcare
- University of Rochester/Strong Memorial Hospital
- Wayne County - Wayne Behavioral Health Network
- Yates County Department of Community Services
- YWCA