# COMMUNITY REFERRAL

**FOR NYS HEALTH HOME CARE MANAGEMENT SERVICES FOR ADULTS**

CNYHHN, Inc. is accepting referrals from the community for enrollment of eligible adults into Health Home Services.

Adults must meet all eligibility requirements to be considered for enrollment.

# HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY

1. Adult currently has active Medicaid or Medicaid Managed Care; AND,
2. Adult resides in one of the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence; AND,
3. Adult meets the NYS Department of Health Eligibility Criteria:
   * 2 or more chronic medical or mental health conditions (See List of Chronic Conditions), or
   * HIV/AIDS, or
   * Sickle Cell Disease, or
   * one or more serious mental illness; AND,
4. Adult has significant behavioral, medical, or social risk factors which can be addressed through care management.

# HOW TO MAKE A REFERRAL

1. Complete the attached Community Referral Application Form.
2. Please make sure the Medicaid CIN Number is on the referral (this is two letters, followed by five numbers, and one letter) ***Example: (AA12345A).***
3. Eligibility Category Information: Make sure to specify the diagnosis: ***Example: (Serious mental Illness – 296.8 Bipolar Disorder NOS; Example: Other Chronic Conditions – COPD).***
4. Risk Factor – Give some detailed information concerning member’ s risk factors: ***Example: (Member is at risk for hospitalization due to non-adherence with medication).***
5. No Referral can be processed without the member’ s consent form, which is included in the Referral. ***Referral will not be processed without a consent per DOH; this can include noted verbal consent.*** CONSENT TO

DISCLOSURE OF HEALTH INFORMATION from CNYHHN Referral is needed.

1. If you are an agency assisting a member in completing a self-referral, make sure to list your contact information along with the member’s information, as the Referral Coordinator may not be able to reach the member, which delays the referral process.
2. If Referrals are coming from an inpatient unit, please provide:
   * ***Name of hospital and contact information for the Discharge Planner***
   * ***Admission and planned discharge date***
   * ***Reason for admission***
3. Send the completed application and consent via secure email or fax, or mail to:

**CNYHHN, Inc.**

**268 Genesee Street, Suite 202**

**Utica, NY 13502** [**Referrals@cnyhealthhome.net**](mailto:%20Referrals@cnyhealthhome.net)

**Fax: 315-624-9428**

**Questions? Call 1-855-784-1262**

**Be sure to include all pages in your submission!**

Approved Adults will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the Adult in Health Home Care Management Services. Health Home services are voluntary and the Adult will be asked to consent during the outreach and engagement process.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Adult Community Referral Application**  Health Home Care Management Services  **PLEASE ATTACH SUPPORTING DOCUMENTATION, DIAGNOSIS AND SIGNED CONSENT IN ORDER TO EXPEDITE THIS REFERRAL** | | | | | |
| **PLEASE PROVIDE THE FOLLOWING INFORMATION** | | | | | |
| **Date of Referral:** | | **Date of Birth:** | | **Gender:** | **Medicaid CIN#: *Required to process*** |
| **Name:** | | | | | |
| **Address:**  **County of Residence: *Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida or St. Lawrence*** | | | | **Medicaid Managed Care Organization Name *(if known):*** | |
| **Social Security# if CIN unavailable:** | |
| **Best way for care manager to contact:** | | | | | |
| **Indicate any need for language/interpretation services; specify language spoken if other than English:** | | | | | |
| **Specify Preferred or Recommended Care Management Agency, if any: Why are you selecting this Agency?** | | | | | |
| **CONTACT INFORMATION FOR PERSON COMPLETING REFERRAL** | | | | | |
| **Name:** | | | | **Title:** | |
| **Organization:** | | | | | |
| **Phone:** | | | | **Email:** | |
| **Is referral from an embedded site (Yes or No)?** | | | | **If yes, which site?** | |
| **ELIGIBILTY INFORMATION** | | | | | |
| 1. Does Individual have significant behavioral, medical, or social risk factors which can be addressed through care management? Check all that apply | | | | | |
|  | Probable risk for adverse event, e.g. death, disability, or nursing home admission | |  | Lack of, or inadequate connectivity with healthcare | |
|  | Learning or cognition issues | |  | Recent release from inpatient setting | |
|  | Deficits in activities of daily living such as dressing, eating, etc. | |  | Non-adherence to treatments or medication(s), or difficulty managing medications | |
|  | Other (*please describe):* | | | | |



|  |  |
| --- | --- |
| **Name:** | |
| **ELIGIBILITY INFORMATION (CONTINUED)** | |
| 1. Does Individual have ONE single qualifying condition of a Serious Mental Illness, Sickle Cell Disease, or HIV/AIDS, or TWO or more chronic conditions? Check all that apply | |
| **SINGLE QUALIFYING CONDITION** | |
|  | **Serious Mental Illness** |
|  | **HIV/AIDS** |
|  | **Sickle Cell Disease** |
| **OR, 2 OR MORE CHRONIC CONDITIONS: please check at least 2 on list below** | |

**Health Home Chronic Conditions, in alphabetical order**

|  |  |
| --- | --- |
|  | Acquired Hemiplegia and Diplegia |
|  | Acquired Paraplegia |
|  | Acquired Quadriplegia |
|  | Acute Lymphoid Leukemia w/wo Remission |
|  | Acute Non-Lymphoid Leukemia w/wo Remission |
|  | Alcoholic Liver Disease |
|  | Alcoholic Polyneuropathy |
|  | Alzheimer's Disease and Other Dementias |
|  | Angina and Ischemic Heart Disease |
|  | Anomalies of Kidney or Urinary Tract |
|  | Apert's Syndrome |
|  | Aplastic Anemia/Red Blood Cell Aplasia |
|  | Ascites and Portal Hypertension |
|  | Asthma |
|  | Atrial Fibrillation |
|  | Attention Deficit / Hyperactivity Disorder |
|  | Benign Prostatic Hyperplasia |
|  | Bi-Polar Disorder |
|  | Blind Loop and Short Bowel Syndrome |
|  | Blindness or Vision Loss |
|  | Bone Malignancy |
|  | Bone Transplant Status |
|  | Brain and Central Nervous System Malignancies |
|  | Breast Malignancy |
|  | Burns - Extreme |
|  | Cardiac Device Status |
|  | Cardiac Dysrhythmia and Conduction Disorders |
|  | Cardiomyopathy |
|  | Cardiovascular Diagnoses requiring ongoing evaluation and treatment |
|  | Cataracts |
|  | Cerebrovascular Disease w or w/o Infarction or Intracranial Hemorrhage |
|  | Chromosomal Anomalies |
|  | Chronic Alcohol Abuse and Dependency |
|  | Chronic Bronchitis |
|  | Chronic Disorders of Arteries and Veins |
|  | Chronic Ear Diagnoses except Hearing Loss |
|  | Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses |
|  | Chronic Eye Diagnoses |
|  | Chronic Gastrointestinal Diagnoses |
|  | Chronic Genitourinary Diagnoses |

|  |  |
| --- | --- |
|  | Chronic Gynecological Diagnoses |
|  | Chronic Hearing Loss |
|  | Chronic Hematological and Immune Diagnoses |
|  | Chronic Infections Except Tuberculosis |
|  | Chronic Joint and Musculoskeletal Diagnoses |
|  | Chronic Lymphoid Leukemia w/wo Remission |
|  | Chronic Metabolic and Endocrine Diagnoses |
|  | Chronic Neuromuscular and Other Neurological Diagnoses |
|  | Chronic Non-Lymphoid Leukemia w/wo Remission |
|  | Chronic Obstructive Pulmonary Disease and Bronchiectasis |
|  | Chronic Pain |
|  | Chronic Pancreatic and/or Liver Disorders (Including Chronic Viral Hepatitis) |
|  | Chronic Pulmonary Diagnoses |
|  | Chronic Renal Failure |
|  | Chronic Skin Ulcer |
|  | Chronic Stress and Anxiety Diagnoses |
|  | Chronic Thyroid Disease |
|  | Chronic Ulcers |
|  | Cirrhosis of the Liver |
|  | Cleft Lip and/or Palate |
|  | Coagulation Disorders |
|  | Cocaine Abuse |
|  | Colon Malignancy |
|  | Complex Cyanotic and Major Cardiac Septal Anomalies |
|  | Conduct, Impulse Control, and Other Disruptive Behavior Disorders |
|  | Congestive Heart Failure |
|  | Connective Tissue Disease and Vasculitis |
|  | Coronary Atherosclerosis |
|  | Coronary Graft Atherosclerosis |
|  | Crystal Arthropathy |
|  | Curvature or Anomaly of the Spine |
|  | Cystic Fibrosis |
|  | Defibrillator Status |
|  | Dementing Disease |
|  | Depression |
|  | Depressive and Other Psychoses |
|  | Developmental Language Disorder |
|  | Developmental Delay NOS/NEC/Mixed |
|  | Diabetes w/wo Complications |
|  | Digestive Malignancy |
|  | |

|  |  |
| --- | --- |
| **NAME:** | |
|  | Disc Disease and Other Chronic Back Diagnoses w/wo Myelopathy |
|  | Diverticulitis |
|  | Drug Abuse Related Diagnoses |
|  | Ear, Nose, and Throat Malignancies |
|  | Eating Disorder |
|  | Endometriosis and Other Significant Chronic Gynecological Diagnoses |
|  | Enterostomy Status |
|  | Epilepsy |
|  | Esophageal Malignancy |
|  | Extrapyramidal Diagnoses |
|  | Extreme Prematurity - Birthweight NOS |
|  | Fitting Artificial Arm or Leg |
|  | Gait Abnormalities |
|  | Gallbladder Disease |
|  | Gastrointestinal Anomalies |
|  | Gastrostomy Status |
|  | Genitourinary Malignancy |
|  | Genitourinary Stoma Status |
|  | Glaucoma |
|  | Gynecological Malignancies |
|  | Hemophilia Factor VIII/IX |
|  | History of Coronary Artery Bypass Graft |
|  | History of Hip Fracture Age > 64 Years |
|  | History of Major Spinal Procedure |
|  | History of Transient Ischemic Attack |
|  | HIV Disease |
|  | Hodgkin's Lymphoma |
|  | Hydrocephalus, Encephalopathy, and Other Brain Anomalies |
|  | Hyperlipidemia |
|  | Hypertension |
|  | Hyperthyroid Disease |
|  | Immune and Leukocyte Disorders |
|  | Inflammatory Bowel Disease |
|  | Intestinal Stoma Status |
|  | Joint Replacement |
|  | Kaposi's Sarcoma |
|  | Kidney Malignancy |
|  | Leg Varicosities with Ulcers or Inflammation |
|  | Liver Malignancy |
|  | Lung Malignancy |
|  | Macular Degeneration |
|  | Major Anomalies of the Kidney and Urinary Tract |
|  | Major Congenital Bone, Cartilage, and Muscle Diagnoses |
|  | Major Congenital Heart Diagnoses Except Valvular |
|  | Major Liver Disease except Alcoholic |
|  | Major Organ Transplant Status |
|  | Major Personality Disorders |
|  | Major Respiratory Anomalies |
|  | Malfunction Coronary Bypass Graft |
|  | Malignancy NOS/NEC |
|  | Mechanical Complication of Cardiac Devices, Implants/Grafts |
|  | Melanoma |

|  |  |
| --- | --- |
|  | Migraine |
|  | Multiple Myeloma w/wo Remission |
|  | Multiple Sclerosis and Other Progressive Neurological Diagnoses |
|  | Neoplasm of Uncertain Behavior |
|  | Nephritis |
|  | Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's |
|  | Neurofibromatosis |
|  | Neurogenic Bladder |
|  | Neurologic Neglect Syndrome |
|  | Neutropenia and Agranulocytosis |
|  | Non-Hodgkin's Lymphoma |
|  | Obesity (BMI at or above 25 for adults and BMI at or above the 85th percentile |
|  | Opioid Abuse |
|  | Osteoarthritis |
|  | Osteoporosis |
|  | Other Chronic Ear, Nose, and Throat Diagnoses |
|  | Other Malignancies |
|  | Pancreatic Malignancy |
|  | Pelvis, Hip, and Femur Deformities |
|  | Peripheral Nerve Diagnoses |
|  | Peripheral Vascular Disease |
|  | Persistent Vegetative State |
|  | Phenylketonuria |
|  | Pituitary and Metabolic Diagnoses |
|  | Plasma Protein Malignancy |
|  | Post-Traumatic Stress Disorder |
|  | Postural and Other Major Spinal Anomalies |
|  | Prematurity - Birthweight < 1000 Grams |
|  | Progressive Muscular Dystrophy and Spinal Muscular Atrophy |
|  | Prostate Disease and Benign Neoplasms – Male |
|  | Prostate Malignancy |
|  | Psoriasis |
|  | Psychiatric Disease (except Schizophrenia) |
|  | Pulmonary Hypertension |
|  | Recurrent Urinary Tract Infections |
|  | Reduction and Other Major Brain Anomalies |
|  | Rheumatoid Arthritis |
|  | Schizophrenia |
|  | Secondary Malignancy |
|  | Secondary Tuberculosis |
|  | Sickle Cell Anemia |
|  | Significant Amputation w/wo Bone Disease |
|  | Significant Skin and Subcutaneous Tissue Diagnoses |
|  | Spina Bifida w/wo Hydrocephalus |
|  | Spinal Stenosis |
|  | Spondyloarthropathy and Other Inflammatory Arthropathies |
|  | Stomach Malignancy |
|  | Tracheostomy Status |
|  | Valvular Disorders |
|  | Vasculitis |
|  | Ventricular Shunt Status |
|  | Vesicostomy Status Vesicoureteral Reflux |

**CONSENT TO DISCLOSURE OF HEALTH INFORMATION FORM 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 healthcare 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. However, 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 HEALTHINFORMATION***

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

Name: Date of Birth:

1. 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, parent, or guardian, please enter relationship ) I give permission to use and disclose my records as described in this document.

Signature Date

**CONSENT TO DISCLOSURE OF HEALTH RECORDS– ATTACHMENTA CNYHYHN, INC.**

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

|  |
| --- |
| **Cayuga County** |
| * CNYHHN, Inc. Care Management * Salvation Army |
| **Herkimer County** |
| * ACR Health * Building Blocks * CNYHHN, Inc. Care Management * Helio Health * ICAN * Presbyterian Residential Community * Salvation Army * The Neighborhood Center * Upstate Cerebral Palsy Care Management |
| **Jefferson County** |
| * ACR Health * Bridging the Gap Care Management * CNYHHN, Inc. North Country * Children’s Home/Care Coordination of Northern New York * CREDO Community Center * HCR Health Care Management, LLC * Mental Health Association in Jefferson Co. * Transitional Living Services of NNY |
| **Lewis County** |
| * ACR Health * Bridging the Gap Care Management * Children’s Home/Care Coordination of Northern New York * CREDO Community Center * HCR Health Care Management * Transitional Living Services of NNY |
| **Madison County** |
| * ACR Health * Building Blocks * CNYHHN, Inc. Care Management * Helio Health * ICAN * Salvation Army |



|  |
| --- |
| **Oneida County** |
| * ACR Health * Building Blocks, LLC * CNYHHN, Inc. Care Management * Helio Health * ICAN * The Neighborhood Center, Inc. * Presbyterian Residential Community * Salvation Army |
| **St. Lawrence County** |
| * ACR Health * Bridging the Gap Care Management * Children’s Home/Care Coordination of Northern New York * HCR Health Care Management, LLC * Mental Health Association in Jefferson Co. and St. Lawrence County Community Services * Transitional Living Services of NNY * United Helpers Mosaic |