

**COMMUNITY REFERRAL**

**FOR NYS HEALTH HOME CARE MANAGEMENT SERVICES FOR CHILDREN/YOUTH**

CNYHHN, INC. is accepting referrals from the community for enrollment of eligible children/youth into Health Home Services.

Children/Youth must meet all eligibility requirements to be considered for enrollment.

**HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY**

1. Child/youth currently has active Medicaid or Medicaid Managed Care; AND
2. Child/Youth resides in one of the following Counties: **Central Region** (Oneida, Herkimer, Madison, and Cayuga County), **North Country** (Jefferson, Lewis and St. Lawrence) OR **Capital District** (Albany, Schenectady and Rensselaer)
3. Child/Youth meets the NYS Department of Health Eligibility Criteria:
   * 2 or more Chronic Conditions (See Appendix A); or
   * 1 Single Qualifying Chronic Medical or Mental Health Condition
     + HIV/AIDS; or
     + Sickle Cell Disease, or
     + Serious Emotional Disturbance; or
     + Complex Trauma
4. Child/Youth 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).***

1. Eligibility Category Information: Make sure to specify the diagnosis: ***Example (Serious mental Illness – 296.8 Bipolar Disorder NOS; Example: Other Chronic Conditions – COPD).***
2. Risk Factor – Give some detailed information concerning child/youth’s risk factors***: Example: (Member is at risk for hospitalization due to non-adherence with medication).***
3. No Referral can be processed without the Parent/Guardian/Legally Authorized Representative for Child/Youth consent form, which is included in the Referral. ***Referral will not be processed without a consent per DOH.*** CONSENT TO DISCLOSURE OF HEALTH INFORMATION from CNYHHN Referral is needed.
4. If you are an agency assisting PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE FOR CHILD/YOUTH 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.
5. 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

4. Send the completed application and consent via secure email or fax, or mail to:

**CNYHHN, Inc.**

**268 Genesee Street Suite 202 Utica, NY 13501** [**Referrals@cnyhealthhome.net**](mailto:Referrals@cnyhealthhome.net) **Fax: 315-624-9428**

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

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

Approved children/youth will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the child/youth in Health Home Care Management Services. Health Home services are voluntary and the Youth and/or Parent/Legal Guardian will be asked to consent during the outreach and engagement process.



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| **Child/Youth Community Referral Application**  Health Home Care Management Services  **PLEASE ATTACH SUPPORTING DOCUMENTATION, DIAGNOSIS AND SIGNED CONSENT IN ORDER TO EXPEDITE THIS REFERAL** | | | | | | | | |
| **DEMOGRAPHICS** | | | | | | | | |
| **Date of Referral:** | | | **Date of Birth:** | | | | **Gender:** | |
| **Child’s Name (Last, First, MI.):** | | | | | | | | |
| **Child’s Current Address:** | | | | | | | **City:** | |
| **Zip Code:** | | | | **County:** | | | **Telephone:** | |
| **INSURANCE** | | | | | | | | |
| **Medicaid CIN # *Required to process*:** | | | | | **Managed Care Organization Plan:** | | | |
| **FOSTER CARE/PREVENTATIVE SERVICES** | | | | | | | | |
| **Child Currently in Foster Care:** | | □ **Yes** | | | □ **No** | | | □ **Unknown** |
| If a child is currently in Foster Care, only the **LOCAL DEPARTMENT OF SOCIAL SERVICES** may complete the referral, which must be completed in Medicaid Analytics & Performance Portal (MAPP) | | | | | | | | |
| **Preventative Services:**  (If any) | □ **Yes** | | | □ **No** | □ **Unknown** | **Contact Information (NPI if known) :** | | |
| **CONSENT TO REFER** | | | | | | | | |
| CONSENT TO MAKE THIS REFERRAL MUST BE OBTAINED FROM THE PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE FOR CHILDREN UP TO THE AGE OF 18. FOR CHILDREN/YOUTH AGES 18-21, OR THAT ARE MARRIED, A PARENT OR PREGNANT MAY  CONSENT ON THEIR OWN BEHALF. Who has provided you with consent to make this referral to CNYHHN, Inc.? | | | | | | | | |
| □ **Parent** | | □ **Guardian** | | | □ **Legally Authorized Representative** | | | □ **Child/Youth**  (18 yrs old, Parent, Pregnant or  Married) |
| **PARENT/LEGAL GUARDIAN DEMOGRAPHICS** | | | | | | | | |
| **Parent/Guardian’s Name (Last, First, MI.)** | | | | | | | | |
| **Address:** | | | | | **City:** | | | |
| **Zip Code:** | | | **County:** | | | | **Telephone:** | |



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| **HEALTH HOME ELIGIBILITY** | | | |
| Eligibility Type (Check only one)   * Two or more Chronic Conditions (Appendix A) 1.   2.  *OR ONE OF THE FOLLOWING SINGLE QUALIFYING CONDITIONS*   * Serious Emotional Disturbance (Written Diagnosis from Appendix B required to process) * HIV/AIDS * Sickle Cell Disease * COMPLEX TRAUMA (Appendix C)   o If yes, Complex Trauma Exposure Screen Form and Referral Cover Sheet are required upon referral (Appendix C) for details. Can be completed by non-  licensed or licensed professional | | Appropriateness Criteria (Check all that apply)   * At risk for adverse event (death, disability, inpatient or nursing home admission, mandated preventative services, or out of home placement) * Has inadequate social/family/housing support or serious disruptions in family relationships * Has inadequate connectivity with healthcare system * Does not adhere to treatments or had difficulty managing medications * Has recently been released from incarceration, placement, detention, or psychiatric hospitalization * Has deficits in activities of daily living, learning orcognition issues * Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home | |
| **OTHER FAMILY/RESIDENTIAL INFORMATION** | | | |
| **Is any other family member currently enrolled in another Health Home?** | | | |
| **Indicate any need for language/interpretation services; specify language spoken if other than English:** | | | |
| **Specify Preferred or Recommended Care Management Agency, if any:** | | | |
| **REFERRAL SOURCE** | | | |
| **Name:** | **Title:** | | **Organization:** |
| **Phone:** | **Email:** | | |
| **Is referral from an embedded site (Yes or No)?** | | **If yes, which site?** | |
| **OTHER APPLICABLE INFORMATION:** | | | |
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## 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 health information so that 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 child/youth’s 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 child/youth’s 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 child/youth’s 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 on the following page. 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 HEALTH INFORMATION***

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

Child/Youth: 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 following page.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in the following page.
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 PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE FOR CHILD/YOUTH UP TO THE AGE OF 18*.* YOUTH AGES 18-21, OR THAT ARE MARRIED, A PARENT OR PREGNANT MAY

CONSENT ON THEIR OWN BEHALF; whose records will be used or disclosed. (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

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

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| Albany County |
| * Building Blocks, LLC * St. Catherine’s Center for Children * Whitney Young |
| Cayuga County |
| * CNYHHN, Inc. Care Management * Salvation Army |
| Herkimer County |
| * Building Blocks, LLC * CNYHHN, Inc. Care Management * ICAN * The Neighborhood Center * Salvation Army * Upstate Cerebral Palsy Care Management |
| Jefferson County |
| * Bridging the Gap Care Management * CNYHHN, Inc. North Country * Children’s Home/Care Coordination of Northern New York * The ARC of Jefferson-St. Lawrence * Transitional Living Services of NNY |
| Lewis County |
| * Bridging the Gap Care Management * Children’s Home/Care Coordination of Northern New York * The ARC of Jefferson-St. Lawrence * Transitional Living Services of NNY |
| Madison County |
| * Building Blocks, LLC * CNYHHN, Inc. Care Management * ICAN * Salvation Army |

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| Oneida County |
| * Building Blocks, LLC * CNYHHN, Inc. Care Management * ICAN * The Neighborhood Center, Inc. * Salvation Army |
| Rensselaer County |
| * Building Blocks, LLC * St. Catherine’s Center for Children * Whitney Young |
| Schenectady County |
| * Building Blocks, LLC * St. Catherine’s Center for Children * Whitney Young |
| St. Lawrence County |
| * Bridging the Gap Care Management * The ARC of Jefferson-St. Lawrence * Transitional Living Services of NNY * United Helpers Mosaic |



# Appendix A: Health Home Chronic Conditions

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| **Name:** | |
|  | 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 |

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|  | 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, 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 |
|  | 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 |
|  | Gastrostomy Status |

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| **Name:** | |
|  | 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 and 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 |

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|  | 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 |

# Appendix B: Serious Emotional Disturbance (SED)

For Health Home Serving Children, SED is a single qualifying chronic condition and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostical and Statistical Manual (DSM) categories: (Schizophrenia Spectrum and Other Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders, Anxiety Disorders, Obsessive Compulsive and Related Disorders, Feeding and Eating Disorders, Gender Dysphoria, Disruptive, Impulse Control, and Conduct Disorders, Personality Disorders, Paraphilic Disorders, Sleep Wake Disorder, Medication Induced Movement Disorders, Attention Deficit Hyperactivity Disorder, Elimination Disorders, Sexual Dysfunctions, and Tic Disorder) as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. Functional limitations requirements for SED must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas as determined by a licensed mental health professional:

* Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); OR
* Family Life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings, and other relatives; behavior in a family setting); OR
* Social Relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); OR
* Self-direction/Self Control (e.g. ability to sustain focused attention for a long period of time to permit completion of age appropriate tasks; behavioral self-control; appropriate judgement and value systems; decision making ability; OR
* Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers, behavior in school)

**Appendix C: Complex Trauma**

**Definition of Complex Trauma:**

1. The term complex trauma incorporates at least:
   1. Infants/Children/or Adolescents exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
   2. The wide-ranging, long term impact of this exposure
2. The nature of the traumatic events:
   1. Often is severe and pervasive, such as abuse or profound neglect;
   2. Usually begins early in life;
   3. Can be disruptive of the child’s development and the formation of health sense of self (with self-regulatory, executive functioning, self-perceptions etc.);
   4. Often occur in the context of the child’s relationship with a caregiver; and
   5. Can interfere with the child’s ability to form a secure attachment bond, which is considered a prerequisite for health social-emotional functioning
3. Many aspects of a child’s healthy physical and mental development rely on this secure attachment, a primary source of safety and stability
4. Wide-ranging, long term adverse effects can include impairments in:
   1. Physiological responses and related neurodevelopment
   2. Emotional Responses
   3. Cognitive processes including the ability to think, learn and concentrate
   4. Impulse control and other self-regulating behavior
   5. Self-image;
   6. Relationships with others

### \*If child/youth eligibility is determined under the Complex Trauma, the Complex Trauma Exposure Screen Form and Referral Cover Sheet are required upon referral, which can be completed by non-licensed or licensed professional. Obtain forms from the following links through the NYS Department of Health Website.

**Complex Trauma Exposure Screen Form** [**https://www.health.ny.gov/health\_care/medicaid/program/medicaid\_health\_homes/docs/final\_complex\_trauma**](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/final_complex_traumaexposure_screen.pdf)[**exposure\_screen.pdf**](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/final_complex_traumaexposure_screen.pdf)

**Referral Cover Sheet** [**https://www.health.ny.gov/health\_care/medicaid/program/medicaid\_health\_homes/docs/final\_complex\_trauma**](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/final_complex_traumareferral_cover_sheet.pdf)[**referral\_cover\_sheet.pdf**](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/final_complex_traumareferral_cover_sheet.pdf)