

Chautauque County Department of Mental Hygiene, a
HHUNY affiliated Health Home Serving the Southern Tier

HHUNY is accepting referrals from the community (health care providers, 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.

HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY

1. Individual currently has active Medicaid; AND;
2. Individual resides in one of the following Counties: Allegany, Cattaraugus, or Chautauque; AND;
3. Individual meets the NYS DOH eligibility criteria of: two chronic conditions, or HIV/AIDS 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 Coordinator

Email: referrals@hhuny.org

Fax: 585-613-7670

Mail: Community Referral Coordinator

New York Care Coordination Program—Health Homes
of Upstate New York

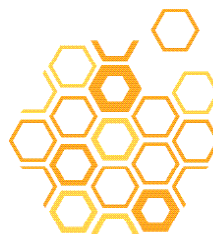
1099 Jay Street, Bldg. J

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.

HHUNY, through its affiliates, also provides Health Homes Services in the counties of Cayuga, Chemung, Cortland, Erie, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Schuyler, Seneca, Steuben, Tompkins, Tioga, Wayne and Yates. Please contact the Community Referral Coordinator to make a referral for services in any of these counties. Please sign consent forms on page 5.

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HHUNY
HEALTH HOMES OF UPSTATE NEW YORK
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How to complete a COMMUNITY REFERRAL TO HHUNY

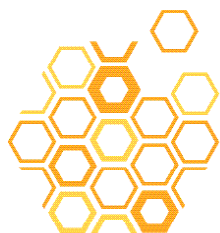
This is a quick cheat sheet to ensure referral sources complete a more accurate Health Home Community Referral. Incorrect or incomplete Health Home referrals impede the processing of the referral, which means a delay in services for the consumer.

When checking boxes for Eligibility and Risk Factors, please provide detailed information. This will give the HHUNY Community Referral Coordinator the information needed to make an appropriate assignment.

Here is a brief check list for completing a HHUNY Community Referral.

- Please make sure the Medicaid CIN Number is on the referral (It is two letters, followed by five numbers, and one letter). Example: **(AA12345A)**.
- Eligibility Category Information: Make sure to specify the diagnosis.
 - Example: Serious mental illness — 296.8 Bipolar Disorder NOS
 - Example: Other Chronic Conditions — COPD
 - If 2 in category C, must provide information on BOTH; Substance Use Disorders included.
- Risk Factor – Give some detail information concerning member's risk factors:
Example: Member is at risk for hospitalization due to non-adherence with medication.
- 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 HHUNY referral is needed.*
- 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 Community Referral Coordinator may not be able to reach member, which delays the referral process.
- 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.

Check to make sure all pages were faxed or (securely) emailed completely.



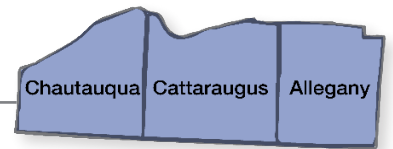
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1099 Jay Street, Building J
Rochester, NY 14611
1-855-613-7659
askhhuny@hhuny.org

FOR MORE INFORMATION, please visit hhuny.org



COMMUNITY REFERRAL APPLICATION



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If the referral is for a youth between the ages of 18-21, please complete the following:

Is the youth in Foster Care? Yes No If yes, please contact your local DSS

Does the youth prefer to be served under the Adult HH system? Yes No

Does the youth prefer to be served under the Children’s HH system? Yes No

If yes, please complete child/youth referral at www.childrenshealthhome.com

IDENTIFYING INFORMATION

Name:	Date of Birth:	
Address:	Medicaid CIN #:	Gender:
	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:		

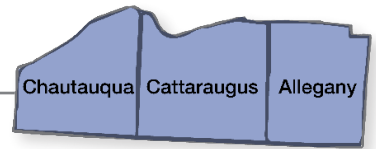
ELIGIBILITY CATEGORY INFORMATION

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
<input type="checkbox"/>	A Serious mental illness	
<input type="checkbox"/>	B HIV/AIDS & the risk of developing another chronic condition	
<input type="checkbox"/>	C Mental Health conditions	
<input type="checkbox"/>	C Substance Abuse Disorder	
<input type="checkbox"/>	C Asthma	
<input type="checkbox"/>	C Diabetes	
<input type="checkbox"/>	C Heart Disease	
<input type="checkbox"/>	C BMI > 25	
<input type="checkbox"/>	C Other Chronic Conditions (Specify)	



COMMUNITY REFERRAL APPLICATION (continued)



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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	
	History of incarceration	
	Most recent psychiatric hospitalization discharge date	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	
	Suicidal Ideation	
	History of Suicide Attempts	
	Homicidal Ideation	
	History of Violence	
	Legal History/Sex Offender Status	
	Unsafe Living Environment	
	Care Manager visitation issues (e.g., household hazards, safety concerns)	
	Other - Specify	

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:	Title:
Organization:	
Phone:	Email:



PERMISSION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

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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:
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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.

3. This information may be disclosed to the persons or organizations listed in Attachment A.

4. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.

5. 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.

6. This permission expires on:

Date:

7. 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)

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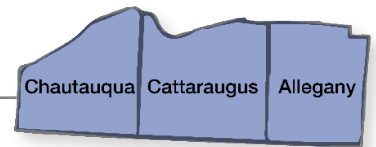
I give permission to use and disclose my records as described in this document.

Signature:	Date:
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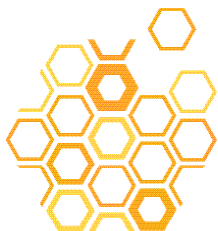
CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A

Chautauqua County Department of Mental Hygiene
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Allegany County Community Services
Buffalo Psychiatric Center
Cattaraugus County Dept. of Community Services
Chautauqua County Department of Mental Hygiene
Clarity Wellness Community (formerly ARA)
Coordinated Care Services, Inc.
Directions in Independent Living
Elmira Psychiatric Center
Evergreen Health Services
HealthNow New York Inc./Amerigroup/BlueCross BlueShield
of Western New York/Anthem

Hillside Family of Agencies
Intandem (formerly Cattaraugus Co. Rehabilitation Center)
New York Care Coordination Program, Inc.
New York State Catholic Health Plan dba Fidelis Care New York
New York State Office of Mental Health
New York State Office of Alcohol and Substance Abuse Services
The Resource Center
Southern Tier Environments for Living
United Healthcare
YourCare Health Plan



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