COMMUNITY REFERRAL
FOR HEALTH HOME CARE MANAGEMENT SERVICES

BestSelf Health Home Services, a HHUNY affiliated Health Home Serving Western New York

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: Erie, Niagara, or Wyoming; AND;
3. Individual meets the NYS DOH eligibility criteria of: two chronic conditions, or HIV/AIDS or Serious Mental Illness (SMI) or Sickle Cell Disease; 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 Referral Team
Email: referrals@hhuny.org
Fax: 585-613-7670
Mail: HHUNY Referral Team New York Care Coordination Program Health Homes of Upstate New York 1150 University Ave, Suite 142A Rochester NY 14607

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 Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Cortland, Genesee, Livingston, Madison, Monroe, Montgomery, 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.

SAVE TIME AND PAPER!

Make referrals online.

Visit www.hhuny.org and click on "Make a Referral" in the right hand corner on any webpage.

HHUNY
HEALTH HOMES OF UPSTATE NEW YORK
Empowering you. Expanding possibilities.

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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 #: CIN has 8 characters total - 2 letters, 5 numbers, 1 letter If CIN unavailable, provide SS #	
	County of Residence:	Gender:
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 two B to be eligible.

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious Mental Illness	
	A	HIV/AIDS & the risk of developing another chronic condition	
	A	Sickle Cell Disease	
	B	Mental Health Conditions	
	B	Substance Use Disorder	
	B	Asthma	
	B	Diabetes	
	B	Heart Disease	
	B	BMI > 25	
	B	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	
	Difficulty adhering to treatments 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:*

***The eligibility determination and agency assignment is communicated to both the referral source and the agency receiving the assignment via secure email.**

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.
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)

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

Signature:	Date:

BestSelf Health Home Services (formerly Lake Shore Health Home Services)

Blossom: Modern Home Care Solutions of Western New York (formerly Companion Care of Rochester)

Buffalo Federation of Neighborhood Centers

Buffalo Homecare dba Care Navigators

Buffalo Psychiatric Center

Carelon Behavioral Health

Catholic Health - Sisters of Charity Hospital

Community Services for Every1

Coordinated Care Services, Inc.

Erie County Office of Mental Health/SPOA

Evergreen Health Services

FreedomCare

GBUAHN Health Home

Harmonia Collaborative Care (formerly Community Concern of WNY)

Highmark Western & Northeastern NY

Hillside

Hispanos Unidos de Buffalo

Horizon Health Services

Intandem

Jericho Road Community Health Center Jewish Family Service of Buffalo and Erie County Living Opportunities of DePaul

Molina Healthcare

Monroe Plan for Medical Care

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

Niagara County Office of Mental Health/SPOA

Niagara Falls Memorial Medical Center

Pinnacle Community Services

RISE Refugee & Immigrant Self Empowerment

Spectrum Human Services Mental Health

Save the Michaels

TruCare Connections Inc.

United Healthcare

Western New York Independent Living, Inc.

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askhhuny@hhuny.org