#  GRHHN COMMUNITY REFERRAL FOR CARE MANAGEMENT

* Community Referrals for Health Home Care Management should be completed for Medicaid and dual eligible Medicaid/Medicare potential members.

Health Home Care Management is being provided by Greater Rochester Health Home Network (GRHHN) and HHUNY network Care Management Agencies for eligible Medicaid members.

# Individuals must meet all eligibility requirements to be considered for enrollment. Please verify the type of care management the person qualifies for:

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| --- |
| **Adult Health Home Care Management** |
| * **Individual is 18 or older or emancipated youth; AND**
* **Individual meets the NYS DOH eligibility criteria of: two chronic conditions**, **OR**
* HIV/AIDS **OR**,
* Sickle Cell Disease
* one or more serious mental illnesses; **AND**
* Individual currently has active Medicaid or Medicaid and Medicare; **AND**
* Individual resides or receives services in Allegany, Chemung, Genesee, Livingston, Monroe, Ontario, Steuben, and Wayne counties; **AND**
* To qualify for enrollment (and ongoing care management services) in the Health Home program, an individual must be assessed and found to have significant behavioral, medical, physical, or social risk factors that require the intensive level of Care Management services provided by the Health Home program
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**How to Make a Care Management Referral:**

* 1. Complete the attached Referral Form, including as much detail as possible to allow the Care Management Agency to determine eligibility and appropriateness for enrollment.
	2. Attach a signed “Consent to Disclosure of Health Information” Form or indicate verbal consent from the member.
	3. Send completed referral and consent **via secure e-mail** or fax, or mail to the following:

|  |
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| **GRHHN HEALTH HOME CARE MANAGEMENT** |
| **GRHHN: Greater Rochester Health Home Network**  |
|  NEW CONTACT INFORMATION AS OF OCT 2025: HHUNY Referral Teamreferrals@hhuny.org1150 University AveSuite 142ARochester NY 14607 Phone: 1-855-613-7659Fax: F: 585-613-7670 |

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and engage the person in services. Care Management services are voluntary and the individual will be asked to consent to receive service during the outreach and engagement process.

**GRHHN Community Referral Application**

|  |  |  |
| --- | --- | --- |
| Name: | Date of Birth: | Gender: |
| Address: | Medicaid CIN #: |
| Medicaid Managed Care Organization Name: |
| County of Residence:  |
| Phone: | Cell Phone and/or E-Mail: |
| Alternative Contact(s) Name, Phone #: |
| Indicate any need for language/interpretation services; specify language spoken if other than English: |

***List Current Medical or Behavioral Health Treatment Providers:***

***Specify Preferred or Recommended Care Management Agency, if any (agency capacity and best options will be considered):***

# Eligibility Category Information – Check All that Apply (See Definitions in Appendix C)

* + - Must meet either A only or B only or C only or two Ds and HAVE active Medicaid to be eligible for Health Home Care Management.

|  |  |  |  |
| --- | --- | --- | --- |
| Check |  | Category | Specify Diagnosis; Provide Available Detail - *REQUIRED or will**not be processed* |
|  | A | Serious mental illness  |  |
|  | B | HIV/AIDS & the risk of developing another chronic condition |  |
|  | C | Sickle Cell Disease |  |
|  | D | Mental Health condition |  |
|  | D | Substance Abuse Disorder |  |
|  | D | Asthma |  |
|  | D | Diabetes |  |
|  | D | Heart Disease |  |
|  | D | BMI > 25 |  |
|  | D | Other Chronic Conditions (Specify) |  |

# Care Management Needs - Check All that Apply and Specify Detail

|  |  |  |
| --- | --- | --- |
| Check | Category | Explain Factor and Care Management Need -*REQUIRED* |
|  | Probable risk for adverse event (e.g. death, disability, inpatient or nursing home admission, mandated preventive services or out of homeplacement) |  |
|  | Repeated ER/Inpatient Use, Including AvoidableER Use |  |
|  | Lack of or inadequate social/family/housingsupport, or serious disruptions in family |  |
|  | Lack of or inadequate connectivity withhealthcare system |  |
|  | Non-adherence to treatments or medication(s)or difficulty managing medications |  |
|  | Recent release from incarceration, placement,detention or psychiatric hospitalization; |  |
|  | Deficits in activities of daily living such as dressing, eating, etc, learning or cognition issues; OR |  |
|  | Is concurrently eligible or enrolled, along witheither their child or caregiver, in a Health Home |  |

**Risk and Safety Concerns – Check all That Apply**

|  |  |  |  |
| --- | --- | --- | --- |
| **Check** | **Concern** | **Check** | **Concern** |
|  | Suicidal Ideation |  | History of Suicide Attempts |
|  | Homicidal Ideation |  | History of Violence |
|  | Active Substance Abuse |  | Unsafe Living Environment |
|  | Other – Specify |  |  |

Provide additional information regarding Risk and Safety Concerns checked above.

# Narrative

Provide any additional information that may be helpful in assignment to a care management agency. If known, include strengths and/or interests of the referred individual. Please also note if this is a transfer request.

# 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 care management and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of care management services, and coordination of care among providers. Your health information may be redisclosed 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

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, please enter relationship .)

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

Signature Date

Verbal Consent obtained via: (Phone/In-Person,) from: (Client or representative)

By Name and Title Date:

# CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A

Health information may be disclosed for purposes of treatment to the organizations listed below. The following organizations provide and/or administer Care Management in Monroe County and/or surrounding area:

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| --- | --- |
| AIM/Corning Council for Assistance | Liberty Resources |
| Allegany County Community Services | Lifespan of Greater Rochester |
| Allegany County Department of Health/OMH/DSS/SPOA | Lakeview Mental Health Services |
| Anthony L. Jordan Health Corporation | Livingston County Mental Health/DOH/DSS/SPOA |
| Arc of Monroe | MC Collaborative |
| Baden Street Settlement | Monroe County Office of Mental Health/DSS/SPOA/DOH |
| Bridges for Brain Injury | Monroe Plan for Medical Care, Inc. |
| Catholic Charities Community Services | MVP Health Care |
| Chemung County Department of Health/OMH/DSS/SPOA | New York State Office of Alcohol & Substance Abuse Svr |
| Children’s Health Home of Upstate New York (CHHUNY) | New York State Office of Mental Health |
| Community Care of Rochester, Inc./ Visiting Nurse Signature Care/UR Medicine Home Care | Ontario County Department of Mental Health/DOH/SPOA/DSS |
| Coordinated Care Services Inc | Orleans Co Dept of Mental Health/DOH/SPOA/DSS |
| DePaul Community Services | Pathways, Inc |
| East House Corporation | Person Centered Housing Options |
| Excellus Health Plans/Centene/Envolve | Regional Primary Care Network/Rushville CHCRochester Regional Health |
| Family Services of Chemung County, Inc. | Rochester Rehabilitation Center |
| Fidelis Care | Rochester Psychiatric Center |
| Finger Lakes Addictions Counseling and Referral (FLACRA) | Salvation Army |
| Genesee Co. Mental Health/SPOA/DSS/DOH | Schuyler County Community Services |
| Greater Rochester Health Home Network (GRHHN) |  Seneca County Department of Mental Health/DOH/SPOA/DSS |
| HCR Care Management, LLC |  Steven Schwarzkopf Community Mental Health Center |
| Health Homes of Upstate New York (HHUNY) | Steuben County Community Mental Health Services/DOH/SPOA/DSS |
| Hillside Children’s Center | United Health Care |
| Huther Doyle Memorial Institute, Inc. | University of Rochester/Strong Memorial Hospital |
| Ibero-American Action League | Villa of Hope |
|  | Wayne ARC |
|  | Wayne County Behavioral Health/DOH/SPOA/DSS |
|  | YWCA |
|  | Wellcare/Highmark  |