

MONROE COUNTY COMMUNITY REFERRAL FOR CARE MANAGEMENT

Community Referrals for Health Home Care Management for Medicaid and dual eligible Medicaid/Medicare persons and Non Medicaid Mental Health Care Management for persons not Medicaid eligible and/or not eligible for Health Home Care Management are now being accepted in Monroe County from providers, community organizations, individuals and/or family members.

- Health Home Care Management is being provided by Greater Rochester Health Home Network (GRHHN) AND Health Homes of Upstate New York – Finger Lakes (HHUNY-Finger Lakes) for eligible Medicaid and Medicaid/Medicare dual eligible persons.
- Non Medicaid Mental Health Care Management is being triaged through the Monroe County Office of Mental Health for individuals with a primary mental health diagnosis who are not eligible for Health Home Care Management.

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

<input type="checkbox"/> Non Medicaid Care Management	<input type="checkbox"/> Health Home Care Management
<input type="checkbox"/> 1. Individual is not eligible for Health Home Care Management services because: <ul style="list-style-type: none"> • Individual is not eligible for Medicaid; OR • Individual does not meet DOH eligibility criteria; AND <input type="checkbox"/> 2. Individual has a primary mental health diagnosis; AND <input type="checkbox"/> 3. Individual resides in Monroe County; AND <input type="checkbox"/> 4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.	<input type="checkbox"/> 1. Individual meets the NYS DOH eligibility criteria of: <ul style="list-style-type: none"> • two chronic conditions, OR • HIV/AIDS <u>and</u> the risk of developing another chronic condition OR, • one or more serious mental illnesses; AND <input type="checkbox"/> 2. Individual currently has active Medicaid or Medicaid and Medicare; AND <input type="checkbox"/> 3. Individual resides or receives services in Monroe County; AND <input type="checkbox"/> 4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.

How to Make a Care Management Referral:

1. Complete the attached Referral Application Form, including as much detail as possible to allow the Health Homes and Monroe County Office of Mental Health / Single Point of Access (SPOA) to determine eligibility. **DIAGNOSIS IS REQUIRED TO PROCESS THE REFERRAL.**
2. Attach a signed "Consent to Disclosure of Health Information" Form
3. Send completed application and Consent via secure e-mail or fax, or mail to ONE of the following:

NON MEDICAID CARE MANAGEMENT	HEALTH HOME CARE MANAGEMENT: HEALTH HOMES	
 Monroe County Office of Mental Health Priority Services	GRHHN:  Greater Rochester Health Home Network	 HHUNY: Health Homes of Upstate New York: Finger Lakes
Lisa Babbitt lbabbitt@monroecounty.gov Phone: (585) 753-2874 Fax: (585) 753-2885 or (585) 753-5015 Mail: Monroe County SPOA 80 West Main St., 4 th Floor Rochester, NY 14614	Amy Nixon - Intake Coordinator anixon@therihn.org Phone: 585-350-1405 Fax: 585-978-7714 Mail: Greater Rochester Health Home Network, LLC 200 Canal View Blvd., Suite 202 Rochester, NY 14623	Tracy Marchese tmarchese@hhuny.org Phone: 585-613-7642 Fax: 585-613-7670 Mail: Community Referral Health Homes of Upstate NY 1099 Jay Street, Bldg. J Rochester, NY 14611

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

Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	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, if Known:

Specify Preferred or Recommended Care Management Agency, if any: _____

Eligibility Category Information – Check All that Apply

Must meet either A only or B only or two Cs and HAVE active Medicaid to be eligible for Health Home Care Management

Must meet A or C as primary diagnosis and NOT HAVE active Medicaid to be eligible for Non Medicaid Care Management

Check	Category	Specify Diagnosis; Provide Available Detail - <u>REQUIRED</u> or will not be processed
<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 condition	
<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)	

Care Management Needs - Check All that Apply and Specify Detail

Check	Category	Explain Factor and Care Management Need - <u>REQUIRED</u>
<input type="checkbox"/>	Probable risk for adverse event	
<input type="checkbox"/>	Repeated ER/Inpatient Use, Including Avoidable ER Use	

	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	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	
	Financial Needs	

Risk and Safety Concerns – Check all That Apply

Check	Concern	Check	Concern
<input type="checkbox"/>	Suicidal Ideation	<input type="checkbox"/>	History of Suicide Attempts
<input type="checkbox"/>	Homicidal Ideation	<input type="checkbox"/>	History of Violence
<input type="checkbox"/>	Active Substance Abuse	<input type="checkbox"/>	Unsafe Living Environment
<input type="checkbox"/>	Other – Specify	<input type="checkbox"/>	

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

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 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

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

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:

- Anthony L. Jordan Health Corporation
- Baden Street Settlement
- Beacon Health Options
- Catholic Charities Community Services
- Catholic Family Center
- Community Place of Greater Rochester
- Community Care of Rochester, Inc. DBA Visiting Nurse Signature Care
- Companion Care of Rochester
- Coordinated Care Services, Inc.
- Delphi Drug and Alcohol Council
- DePaul Community Services
- East House Corporation
- Epilepsy-Pralid, Inc.
- Finger Lakes Addictions Counseling and Referral (FLACRA)
- Greater Rochester Health Home Network (GRHHN)
HCR Care Management LLC
- Health Homes of Upstate New York (HHUNY)
Hickok Center
- Hillside Children's Center
- Huther Doyle Memorial Institute, Inc.
- Ibero-American Action League
- Jefferson Family Medicine
- L. Woerner, Inc. (dba HCR)
- Lifespan of Greater Rochester
- Life Time Care
- Monroe County Office of Mental Health
- Monroe Plan for Medical Care, Inc.
- New York Care Coordination Program, Inc.
- Rehabilitation Counseling & Assessment Services, LLC.
- Rochester Regional Health - Unity/GMHC/RMHC/Rochester General Hospital
- Rochester Rehabilitation Center
- Rochester Psychiatric Center
- Steven Schwarzkopf Community Mental Health Center
- Trillium Health
- University of Rochester/Strong Memorial Hospital
- Venture Forthe, Inc.
- Villa of Hope
- YWCA