

MONROE COUNTY REFERRAL FOR CHILD AND YOUTH CARE MANAGEMENT/CARE COORDINATION

Community Referrals for Health Home Care Management and Non Medicaid Mental Health Care Coordination submitted by providers, community organizations, individuals and/ or family members are now being accepted by Monroe County Child & Youth SPOA.

- Health Homes Serving Children for Monroe County (for eligible Medicaid persons) include Children’s Health Homes of Upstate New York (CHHUNY) and Encompass Catholic Charities Children’s Health Home.
- Non Medicaid Mental Health Care Management is being provided by Villa of Hope.

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 Coordination	<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"/> 1. Individual meets the NYS DOH eligibility criteria of: <ul style="list-style-type: none"> • two chronic conditions, OR • HIV/AIDS OR, • Serious Emotional Disturbance (SED) OR, • complex trauma (screening form required); AND
<input type="checkbox"/> 2. Individual has a primary mental health diagnosis; AND	<input type="checkbox"/> 2. Individual currently has active Medicaid; AND
<input type="checkbox"/> 3. Individual resides in Monroe County; 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.	<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 Monroe County Office of Mental Health / Single Point of Access (SPOA) to determine eligibility. **DIAGNOSIS IS REQUIRED TO PROCESS THE REFERRAL.**
2. Attach a completed “Consent to Refer” form. (page 5 in this document)
3. Send completed application and Consent to the following:

 <p>Monroe County Office of Mental Health Priority Services</p>
<p>Child & Youth SPOA childspoa@monroecounty.gov Phone: (585) 753-2881 Fax: (585) 324-4322 Mail: Monroe County C&Y SPOA 1099 Jay Street, Bld J Suite 203A Rochester, NY 14611</p>

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 and parent or legal guardian will be asked to consent during the outreach and engagement process.

Community Referral Application

Identifying Information for Youth Being Referred		
Youth Name:	Date of Birth:	Gender:
Youth Address:	Medicaid CIN #:	
	Medicaid Managed Care Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	County of Residence:	
Youth in Foster Care: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Youth Phone:	Youth E-Mail:	
Indicate any need for language/interpretation services for youth, family or guardian; specify language spoken.		
Identifying Information for Individual Giving Consent to Refer		
Name:	Relationship to Youth:	
Address: <input type="checkbox"/> <i>Check if same as Youth</i>	<input type="checkbox"/> Parent	
	<input type="checkbox"/> Guardian	
	<input type="checkbox"/> Legally Authorized Representative	
	<input type="checkbox"/> Self (18 years or older)	
	<input type="checkbox"/> Self (Under 18 but is parent, pregnant or married)	
Phone:	E-Mail:	
Preferred Communication: (drop down choices)	Preferred Time of Day: (drop down choices)	
Identifying Information for Additional Contacts		
Name:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	
Address:	Phone:	
	E-Mail	
Name:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	
Address:	Phone:	
	E-Mail	
Information for Services Currently Being Provided		
List Current Medical and/or Behavioral Health Treatment Providers, if known:		
Is youth currently receiving child preventive services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Is Parent or Guardian enrolled in Health Home Care Management? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, please provide Medicaid CIN#:		

Eligibility Category Information – Check All that Apply		
Health Home Care Management: Must meet either A only or B only or C only or two Ds and HAVE active Medicaid. Non Medicaid Care Management: Must meet A or C as primary diagnosis and NOT HAVE active Medicaid.		
<i>PLEASE NOTE: DIAGNOSIS WITH DATE DIAGNOSIS ESTABLISHED ARE REQUIRED TO PROCESS THE REFERRAL</i>		
Check	Category	Specify Diagnosis and provide available detail:
	A Serious emotional disturbance	
	B HIV/AIDS & the risk of developing another chronic condition	
	C Complex Trauma	
	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			
Check	Need	Check	Need
	At risk for adverse event (e.g. death, disability, inpatient admission, mandated preventive 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 has difficulty managing medications
	Has recently been released from incarceration, placement or detention		Has recently been released from psychiatric hospitalization
	Has deficits in activities of daily living such as dressing, eating, etc.		Has learning or cognition issues

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
	Sexual Aggression		Runaway
	Cruelty to animals		Fire Setting
	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

Contact Information for Person Completing Referral	
Name:	Title:
Organization:	
Phone:	Email:

Consent to Refer

The person whose information may be used or disclosed is:

Name: _____.

Date of Birth: _____.

Use and disclosure of this information is permitted only as necessary for the purposes of referring to NYS Medicaid Analytics Performance Portal (MAPP) to determine Health Home eligibility.

I am the person whose information will be used or disclosed, or that individual's personal representative.

I give permission to submit referral to MAPP.

Signature

Date

If personal representative, please print name and enter relationship below:

Printed Name

Relationship

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 coordination and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of care coordination 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 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.

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 the 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 Villa of Hope and the Monroe County Office of Mental Health.
3. This information may be disclosed by any person or organization that holds a record described above.
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 information will be used or disclosed, or that individual's personal representative.

I give permission to submit referral to MAPP.

Signature

Date

If personal representative, please print name and enter relationship below:

Printed Name

Relationship