



**COMMUNITY REFERRAL**  
**FOR NYS HEALTH HOME CARE MANAGEMENT SERVICES FOR ADULTS**

CNYHHN, Inc. is accepting referrals from the community for enrollment of eligible adults into Health Home Services. Adults must meet all eligibility requirements to be considered for enrollment.

**HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY**

1. Adult currently has active Medicaid or Medicaid Managed Care; AND,
2. Adult resides in one of the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence; AND,
3. Adult meets the NYS Department of Health Eligibility Criteria:
  - 2 or more chronic medical or mental health conditions (See List of Chronic Conditions), or
  - HIV/AIDS, or
  - one or more serious mental illness; AND,
4. Adult has significant behavioral, medical, or social risk factors which can be addressed through care management.

**HOW TO MAKE A REFERRAL**

1. Complete the attached Community Referral Application Form, including as much detail as possible to allow CNYHHN, Inc. to verify eligibility for Health Home Care Management Services.
2. Attach a signed *Consent to Disclosure of Health Information* Form.
3. Attach supporting documentation of diagnosis (if available).
4. Send the completed application and consent via secure email or fax, or mail to:

**CNYHHN, Inc.**  
**1500 Genesee St., Utica, NY 13502**  
**[Referrals@cnyhealthhome.net](mailto:Referrals@cnyhealthhome.net)**  
**Fax: 315-624-9428**  
**Questions? Call 1-855-784-1262**  
**Be sure to include all pages in your submission!**

Approved Adults will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the Adult in Health Home Care Management Services. Health Home services are voluntary and the Adult will be asked to consent during the outreach and engagement process.





# Adult Community Referral Application

Health Home Care Management Services

**PLEASE ATTACH SUPPORTING DOCUMENTATION, DIAGNOSIS AND SIGNED CONSENT  
IN ORDER TO EXPEDITE THIS REFERRAL**

## PLEASE PROVIDE THE FOLLOWING INFORMATION

<b>Date of Referral:</b>	<b>Date of Birth:</b>	<b>Gender:</b>	<b>Medicaid CIN#: <i>Required to process</i></b>
<b>Name:</b>			
		<b>Medicaid Managed Care Organization Name (if known):</b>	
		<b>Social Security# if CIN unavailable:</b>	
<b>Best way for care manager to contact:</b>			
<b>Indicate any need for language/interpretation services; specify language spoken if other than English:</b>			

**Specify Preferred or Recommended Care Management Agency, if any:  
Why are you selecting this Agency?**

## CONTACT INFORMATION FOR PERSON COMPLETING REFERRAL

<b>Name:</b>	<b>Title:</b>
<b>Organization:</b>	
<b>Phone:</b>	<b>Email:</b>
<b>Is referral from an embedded site (Yes or No)?</b>	<b>If yes, which site?</b>

## ELIGIBILITY INFORMATION

1. Does Individual have significant behavioral, medical, or social risk factors which can be addressed through care management? Check all that apply

<input type="checkbox"/>	Probable risk for adverse event, e.g. death, disability, or nursing home admission	<input type="checkbox"/>	Lack of, or inadequate connectivity with healthcare
<input type="checkbox"/>	Learning or cognition issues	<input type="checkbox"/>	Recent release from inpatient setting
<input type="checkbox"/>	Deficits in activities of daily living such as dressing, eating, etc.	<input type="checkbox"/>	Non-adherence to treatments or medication(s), or difficulty managing medications
<input type="checkbox"/>	Other (please describe):		



Name:

**ELIGIBILITY INFORMATION (CONTINUED)**

1. Does Individual have ONE single qualifying condition of a Serious Mental Illness or HIV/AIDS, or TWO or more chronic conditions? Check all that apply

**SINGLE QUALIFYING CONDITION**

**Serious Mental Illness**

**HIV/AIDS**

**OR, 2 OR MORE CHRONIC CONDITIONS: please check at least 2 on list below**

**Health Home Chronic Conditions, in alphabetical order**

Acquired or Hemiplegia and Diplegia	Cardiovascular Diagnoses requiring ongoing evaluation and treatment
Acquired or Paraplegia	Cataracts
Acquired or Quadriplegia	Cerebrovascular Disease w/wo Infarction or Intracranial Hemorrhage
Acute Lymphoid Leukemia w/wo Remission	Chromosomal Anomalies
Acute Non-Lymphoid Leukemia w/wo Remission	Chronic Alcohol Abuse and Dependency
Alcoholic Liver Disease	Chronic Bronchitis
Alcoholic Polyneuropathy	Chronic Disorders of Arteries and Veins
Alzheimer's Disease and Other Dementias	Chronic Ear Diagnoses except Hearing Loss
Angina and Ischemic Heart Disease	Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses
Anomalies of Kidney or Urinary Tract	Chronic Eye Diagnoses
Apert's Syndrome	Chronic Gastrointestinal Diagnoses
Aplastic Anemia/Red Blood Cell Aplasia	Chronic Genitourinary Diagnoses
Ascites and Portal Hypertension	Chronic Gynecological Diagnoses
Asthma	Chronic Hearing Loss
Atrial Fibrillation	Chronic Hematological and Immune Diagnoses
Attention Deficit / Hyperactivity Disorder	Chronic Infections Except Tuberculosis
Benign Prostatic Hyperplasia	Chronic Joint and Musculoskeletal Diagnoses
Bi-Polar Disorder	Chronic Lymphoid Leukemia w/wo Remission
Blind Loop and Short Bowel Syndrome	Chronic Metabolic and Endocrine Diagnoses
Blindness or Vision Loss	Chronic Neuromuscular and Other Neurological Diagnoses
Bone Malignancy	Chronic Non-Lymphoid Leukemia w/wo Remission
Bone Transplant Status	Chronic Obstructive Pulmonary Disease and Bronchiectasis
Brain and Central Nervous System Malignancies	Chronic Pain
Breast Malignancy	Chronic Pancreatic and/or Liver Disorders (Including Chronic Viral Hepatitis)
Burns - Extreme	Chronic Pulmonary Diagnoses
Cardiac Device Status	Chronic Renal Failure
Cardiac Dysrhythmia and Conduction Disorders	Chronic Skin Ulcer
Cardiomyopathy	Chronic Stress and Anxiety Diagnoses

Name:

Chronic Thyroid Disease	Genitourinary Stoma Status
Chronic Ulcers	Glaucoma
Cirrhosis of the Liver	Gynecological Malignancies
Cleft Lip and/or Palate	Hemophilia Factor VIII/IX
Coagulation Disorders	History of Coronary Artery Bypass Graft
Cocaine Abuse	History of Hip Fracture Age > 64 Years
Colon Malignancy	History of Major Spinal Procedure
Complex Cyanotic and Major Cardiac Septal Anomalies	History of Transient Ischemic Attack
Conduct, Impulse Control, and Other Disruptive Behavior Disorders	HIV Disease
Congestive Heart Failure	Hodgkin's Lymphoma
Connective Tissue Disease and Vasculitis	Hydrocephalus, Encephalopathy, and Other Brain Anomalies
Coronary Atherosclerosis	Hyperlipidemia
Coronary Graft Atherosclerosis	Hypertension
Crystal Arthropathy	Hyperthyroid Disease
Curvature or Anomaly of the Spine	Immune and Leukocyte Disorders
Cystic Fibrosis	Inflammatory Bowel Disease
Defibrillator Status	Intestinal Stoma Status
Dementing Disease	Joint Replacement
Depression	Kaposi's Sarcoma
Depressive and Other Psychoses	Kidney Malignancy
Diabetes w/wo Complications	Leg Varicosities with Ulcers or Inflammation
Digestive Malignancy	Liver Malignancy
Disc Disease and Other Chronic Back Diagnoses w/wo Myelopathy	Lung Malignancy
Diverticulitis	Macular Degeneration
Drug Abuse Related Diagnoses	Major Anomalies of the Kidney and Urinary Tract
Ear, Nose, and Throat Malignancies	Major Congenital Bone, Cartilage, and Muscle Diagnoses
Eating Disorder	Major Congenital Heart Diagnosis Except Valvular
Endometriosis and Other Significant Chronic Gynecological Diagnoses	Major Liver Disease except Alcoholic
Enterostomy Status	Major Organ Transplant Status
Epilepsy	Major Personality Disorders
Esophageal Malignancy	Major Respiratory Anomalies
Extrapyramidal Diagnoses	Malfunction Coronary Bypass Graft
Extreme Prematurity - Birthweight NOS	Malignancy NOS/NEC
Fitting Artificial Arm or Leg	Mechanical Complication of Cardiac Devices, Implants and Grafts
Gait Abnormalities	Melanoma
Gallbladder Disease	Migraine
Gastrointestinal Anomalies	Multiple Myeloma w/wo Remission
Gastrostomy Status	Multiple Sclerosis and Other Progressive Neurological Diagnoses
Genitourinary Malignancy	Neoplasm of Uncertain Behavior

Name:

Nephritis	Significant Amputation w/wo Bone Disease
Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's	Significant Skin and Subcutaneous Tissue Diagnoses
Neurofibromatosis	Spina Bifida w/wo Hydrocephalus
Neurogenic Bladder	Spinal Stenosis
Neurologic Neglect Syndrome	Spondyloarthropathy and Other Inflammatory Arthropathies
Neutropenia and Agranulocytosis	Stomach Malignancy
Non-Hodgkin's Lymphoma	Tracheostomy Status
Obesity	Valvular Disorders
Opioid Abuse	Vasculitis
Osteoarthritis	Ventricular Shunt Status
Osteoporosis	
Other Chronic Ear, Nose, and Throat Diagnoses	
Other Malignancies	
Pancreatic Malignancy	
Pelvis, Hip, and Femur Deformities	
Peripheral Nerve Diagnoses	
Peripheral Vascular Disease	
Persistent Vegetative State	
Phenylketonuria	
Pituitary and Metabolic Diagnoses	
Plasma Protein Malignancy	
Post-Traumatic Stress Disorder	
Postural and Other Major Spinal Anomalies	
Prematurity - Birthweight < 1000 Grams	
Progressive Muscular Dystrophy and Spinal Muscular Atrophy	
Prostate Disease and Benign Neoplasms - Male	
Prostate Malignancy	
Psoriasis	
Psychiatric Disease (except Schizophrenia)	
Pulmonary Hypertension	
Progressive Muscular Dystrophy and Spinal Muscular Atrophy	
Recurrent Urinary Tract Infections	
Reduction and Other Major Brain Anomalies	
Rheumatoid Arthritis	
Schizophrenia	
Secondary Malignancy	
Secondary Tuberculosis	
Sickle Cell Anemia	



## **CONSENT TO DISCLOSURE OF HEALTH INFORMATION FORM 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 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. However, 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, parent, or guardian, please enter relationship \_\_\_\_\_) I give permission to use and disclose my records as described in this document.

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Signature

Date



## **CONSENT TO DISCLOSURE OF HEALTH RECORDS – ATTACHMENT A CNYHHN, Inc.**

Health information may be disclosed for purposes of treatment to the people and organizations listed below:

- ACR Health
- Carthage Area Hospital
- Cayuga County Mental Health Center
- CNYHHN, Inc. Care Management
- Children’s Home/Care Coordination of Northern New York
- CHC of the North Country
- CREDO Community Center
- Excellus Health Plans
- Fidelis Care
- HCR Care Management, LLC
- Kids Oneida, Inc.
- Liberty Resources
- Local Social Services Departments
- NYS Alcohol/Drug Dependency
- NYS Mental Health Services
- MVP Health Care
- Mohawk Valley Psychiatric Center
- New York State Department of Health
- St. Lawrence Co. Community Services
- St. Lawrence Psychiatric Center
- Supportive Housing Agencies
- The Neighborhood Center, Inc.
- Transitional Living Services of Northern NY
- United Healthcare
- United Helpers dba Mosaic
- Unity House of Cayuga County
- Upstate Cerebral Palsy Care Management

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