CNYHHN
Care Management Services
Where Care Comes Together

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
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.

CNYHHN Care Management Services Where Care Comes Together
CHILDREN'SHHN of the Capital District Care Management Services Where Care Comes Together
NCHHN Care Management Services Where Care Comes Together

Adult Community Referral Application

Health Home Care Management Services

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

PLEASE PROVIDE THE FOLLOWING INFORMATION			
Date of Referral:	**Date of Birth:**	**Gender:**	**Medicaid CIN#:** ***Required to process***
Name:			
Address: **County of Residence:** ***Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida or St. Lawrence***		**Medicaid Managed Care Organization Name** ***(if known):*** **Social Security# if CIN unavailable:**	
Best way for care manager to contact:			
Indicate any need for language/interpretation services; specify language spoken if other than English:			
Specify Preferred or Recommended Care Management Agency, if any: **Why are you selecting this Agency?**			

CONTACT INFORMATION FOR PERSON COMPLETING REFERRAL	
Name:	**Title:**
Organization:	
Phone:	**Email:**
Is referral from an embedded site (Yes or No)?	**If yes, which site?**

ELIGIBILTY INFORMATION

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

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

_____

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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