

**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.



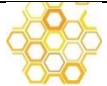
- Health Home Care Management is being provided by Greater Rochester Health Home Network (GRHHN) AND Health Homes of Upstate New York – Finger Lakes (HHUNY-Finger Lakes) for eligible Medicaid and Medicaid/Medicare dual eligible persons.
- Non Medicaid Mental Health Care Management is being triaged through 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"/> <b>Non Medicaid Care Management</b>	<input type="checkbox"/> <b>Health Home Care Management</b>
<input type="checkbox"/> 1. Individual is <b>not</b> eligible for Health Home Care Management services because: <ul style="list-style-type: none"> <li>• Individual is not eligible for Medicaid; <b>OR</b></li> <li>• Individual does not meet DOH eligibility criteria; <b>AND</b></li> </ul> <input type="checkbox"/> 2. Individual has a primary mental health diagnosis; <b>AND</b> <input type="checkbox"/> 3. Individual resides in Monroe County; <b>AND</b> <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"> <li>• two chronic conditions, <b>OR</b></li> <li>• HIV/AIDS <u>and</u> the risk of developing another chronic condition <b>OR</b>,</li> <li>• one or more serious mental illnesses; <b>AND</b></li> </ul> <input type="checkbox"/> 2. Individual currently has active Medicaid or Medicaid and Medicare; <b>AND</b> <input type="checkbox"/> 3. Individual resides or receives services in Monroe County; <b>AND</b> <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:

<b>NON MEDICAID CARE MANAGEMENT</b>	<b>HEALTH HOME CARE MANAGEMENT: HEALTH HOMES</b>	
 <b>Monroe County Office of Mental Health Priority Services</b>	<b>GRHHN:</b>  <b>Greater Rochester Health Home Network</b>	 <b>HHUNY:</b> <b>Health Homes of Upstate New York: Finger Lakes</b>
Lisa Babbitt <a href="mailto:lbabbitt@monroecounty.gov">lbabbitt@monroecounty.gov</a> Phone: (585) 753-2874 Fax: (585) 753-2885 Mail: Monroe County SPOA 1099 Jay St., Bldg J, 3 <sup>rd</sup> Floor Rochester, NY 14611	Traci DeLario - Intake Coordinator <a href="mailto:grhhnintake@flpps.org">grhhnintake@flpps.org</a> Phone: 585-350-1400 Fax: 585-978-7714 Mail: Greater Rochester Health Home Network, LLC 1 South Washington St, Suite 200 Rochester, NY 14614	Tracy Marchese <a href="mailto:referrals@hhuny.org">referrals@hhuny.org</a> Phone: 1-855-613-7659 Fax: 585-613-7670 Mail: Community Referral Health Homes of Upstate NY 1150 University Ave, Suite 142A Rochester, NY 14607 Online Referral at <a href="http://www.hhuny.org">www.hhuny.org</a>

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:	

Indicate any need for language/interpretation services; specify language spoken if other than English:

Identifying Information for Additional Contacts	
Name:	Phone:

Information for Services Currently Being Provided
List Current Medical and/or Behavioral Health Treatment Providers, if known:

*Specify Preferred or Recommended Care Management Agency, if any*

Eligibility Category Information – Check All that Apply
<p><b>Health Home Care Management:</b> Must meet either <b>A only</b> or <b>B only</b> or <b>two Cs</b> and <b>HAVE active Medicaid.</b></p> <p><b>Non Medicaid Care Management:</b> Must meet <b>A or C</b> as <b>primary diagnosis</b> and <b>NOT HAVE active Medicaid.</b></p>

Check	Category	Specify Diagnosis; Provide available detail - <i><b>REQUIRED</b></i> or will not be processed
	A Serious emotional disturbance	
	B HIV/AIDS & the risk of developing another chronic condition	
	C Mental Health condition	
	C Substance Abuse Disorder	
	C Asthma	
	C Diabetes	
	C Heart Disease	
	C BMI > 25	
	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>
	Probable risk for adverse event	
	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	

Care Management Needs - Check All that Apply and Specify Detail (Continued)		
Check	Category	Explain Factor and Care Management Need - <u>REQUIRED</u>
	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
	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

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

Verbal Consent obtained via: (Phone/In-Person) \_\_\_\_\_ from: (Client or Representative) \_\_\_\_\_

By Name and Title: \_\_\_\_\_ Date: \_\_\_\_\_

## Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Monroe County.

Access-VR	Ibero-American Action League
Action for a Better Community	Interim Mental Health
Adult Protective Services	Jewish Family Service of Rochester
Anthony Jordan Health Center	John L. Norris ATC
Baden Street Settlement	Liberty Resources
Balanced Care	Lifetime Care
Beacon Health Strategies, LLC (Medicaid Managed Care Organization)	MC Collaborative
Blue Cross/Blue Shield of Western New York/Health Now (Medicaid Managed Care Organization)	Mental Health Association of Rochester
Catholic Family Center	Molina Healthcare
Catholic Charities Community Services	Monroe Correctional Facility
Center for Youth	Monroe County Department of Human Services
Child Protective Services	Monroe County Jail
Community Care of Rochester, Inc. DBA Visiting Nurse Signature Care	Monroe County Office of Mental Health
Community Place of Greater Rochester	Monroe Plan for Medical Care, Inc.
Companion Care of Rochester	MVP (Medicaid Managed Care Organization)
Compeer Rochester	National Alliance on Mental Illness (NAMI)
Conifer Park, Inc.	New York Care Coordination Program, Inc.
Coordinated Care Services, Inc.	NY Connects
Correct Care Solutions	Office of Addiction Services and Supports (OASAS)
Crestwood Children's Center	Office of People with Developmental Disabilities (OPWDD)
Daisy Marquis Jones Women's Residence	OnTrack NY
Delphi Drug & Alcohol Services	NYS Office of Mental Health
DePaul Community Services	Pathways Methadone Maintenance Treatment Program
Department of Corrections and Community Supervision	Pathway Houses of Rochester
East House Corporation	Prime Care (effective 1/14/18 formally known as Correct Care Solutions)
Easter Seals New York	Puerto Rican Youth Development
Eldersource / Lifespan	Recovery Options Made Easy (ROME)
Endeavor Counseling Services	Rehabilitation Counseling & Assessment Services, LLC.
Epilepsy-Pralid, Inc.	Rochester/Monroe Recovery Network
Excellus/Centene/Evolve Health (Medicaid Managed Care Organization)	Rochester Regional Health
Fidelis (Medicaid Managed Care Organization)	Rochester Psychiatric Center
Finger Lakes Area Counseling and Recovery Agency (FLACRA)	Rochester Rehabilitation Center
Finger Lakes Developmental Disabilities Services Office (DDSO)	Spectrum Health and Human Services
Gavia LifeCare Center	Steven Schwarzkopf Community Mental Health Center
Greater Rochester Health Home Network (GRHHN)	The Healing Connection, Inc.
Genesee County Mental Health Clinic	Threshold Center
HCR Home Care	Trillium Health
Health Homes of Upstate New York (HHUNY)	United Health Care (Medicaid Managed Care Organization)
Helio Health, Inc.	University of Rochester/Strong Memorial Hospital
Hickok Center	Urban League of Rochester
Hillside Family of Agencies	YWCA Supportive Living Program
Hillside Children's Center	Venture For the, Inc.
Huther-Doyle Memorial Institute, Inc.	Veteran's Administration
	Veteran's Outreach Center
	Villa of Hope
	Westfall Associates