GRHHN 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 from providers, community organizations, individuals and/or family members.

- Health Home Care Management is being provided by Greater Rochester Health Home Network (GRHHN) and other Health Homes for eligible Medicaid and Medicaid/Medicare dual eligible persons.
- Non Medicaid Mental Health Care Management is being triaged through the County Single Points of Contact (SPOA) or Office of Mental Health for individuals with a primary mental health diagnosis or children who are not eligible for Health Home Care Management. See Western Region SPOA list attached.

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

☐ Children Health Home Care Management	☐ Adult Health Home Care Management
☐ 1. Individual is age 1-21 years of age ☐ 2. Individual meets the NYSDOH eligibility criteria of: • two chronic conditions, **OR** • HIV/AIDS **OR**, • serious emotional disturbance **OR**; • complex trauma; **AND** ☐ 3. Individual currently has active Medicaid or Medicaid and Medicare; **AND** ☐ 4. Individual resides or receives services in Monroe, Seneca, Genesee, Orleans, Allegany, Steuben, Livingston, Wayne, Ontario, Cayuga, Chemung, Yates, and Wyoming counties.; **AND** ☐ 5. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.	☐ 1. Individual is 21 or older or emancipated youth; **AND** ☐ 2. Individual meets the NYS DOH eligibility criteria of: • two chronic conditions, **OR** • HIV/AIDS **OR**, • one or more serious mental illnesses; **AND** ☐ 3. Individual currently has active Medicaid or Medicaid and Medicare; **AND** ☐ 4. Individual resides or receives services in Monroe County; **AND** ☐ 5. 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	GRHHN HEALTH HOME CARE MANAGEMENT
Monroe County Office of Mental Health Priority Services	**GRHHN: Greater Rochester Health Home Network** GREATER **Rochester Health Home** Network
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., 4th Floor Rochester, NY 14614	GRHHN Intake Team - grhhnintake@flpps.org Phone: 585-350-1400 Fax: 585-978-7714 Mail: Greater Rochester Health Home Network 2100 Brighton Henrietta Townline Rd, Suite 200 Rochester, NY 14623

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 or their parent/guardian will be asked to consent to receive care management service during the outreach and engagement process.

GRHHN Community Referral Application

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	Cell Phone and/or E-Mail:	
Alternative Contact(s) Name, Phone #:		
Indicate any need for language/interpretation services; specify language spoken if other than English:		
Is the individual currently in Foster Care? ☐ Yes ☐ No ☐ Unknown If yes, only Local DSS may complete the referral – please contact the appropriate county on page 8-9.		
If the individual is an adult, please see the consent form attached. Please ask them to complete and sign it to allow GRHHN to share their information for referral purposes.		
If the individual is a child, a consent to refer is required. Who provided you with consent to make this referral to GRHHN? ☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Child/Youth who is: (circle one) 18 years or older A parent Pregnant Married		
Consenter Information: Please indicate who provided you with consent to make this referral to GRHHN: Name:_____ Phone number:_____ Relationship to child:		
Is the child/youth's parent or guardian currently enrolled in the Health Home Program? ☐ Yes ☐ No ☐ Unknown Which Health Home, if known:_____ Parent/Guardian CIN Number: _____ If needs exist and appropriate for care management, please submit a separate referral for the parent or guardian.		
Is the child/youth current receiving preventive services? ☐ Yes ☐ No ☐ Unknown If yes, please specify name of provider:_____		
Is the child/youth currently admitted to an inpatient facility? ☐ Yes ☐ No ☐ Unknown If yes, please specify the name of facility:_____ Expected discharge date:_____		

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 (See Definitions in Appendix C)

- Must meet either A only or B only or C only or two Ds and HAVE active Medicaid to be eligible for Health Home Care Management;
- Must meet A or have a mental health condition as primary diagnosis and NOT HAVE active Medicaid to be eligible for Non Medicaid Care Management

Check		Category	Specify Diagnosis; Provide Available Detail - *REQUIRED or will not be processed*
☐	A	Serious mental illness or Serious Emotional Disturbance	
☐	B	HIV/AIDS & the risk of developing another chronic condition	
☐	C	Complex Trauma – Also requires completion of the Complex Trauma Referral Cover Sheet and Exposure Screen	
☐	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 and Specify Detail

Check	Category	Explain Factor and Care Management Need - *REQUIRED*
☐	Probable risk for adverse event (e.g. death, disability, inpatient or nursing home admission, mandated preventive services or out of home placement)	
☐	Repeated ER/Inpatient Use, Including Avoidable ER Use	
☐	Lack of or inadequate social/family/housing support, or serious disruptions in family	
☐	Lack of or inadequate connectivity with healthcare system	
☐	Non-adherence to treatments or medication(s) or difficulty managing medications	
☐	Recent release from incarceration, placement, detention or psychiatric hospitalization;	
☐	Deficits in activities of daily living such as dressing, eating, etc, learning or cognition issues; OR	
☐	Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home	

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:

For ADULTS: 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: _____

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 and/or surrounding area:

AC Center, Inc DBA Trillium Health	Liberty Resources
Allegany County Community Services	Lifespan of Greater Rochester
Allegany County Department of Health/OMH/DSS/SPOA	Lake View Mental Health Services
Allegany Rehab Associates	Livingston County Mental Health/DOH/DSS/SPOA
Anthony L. Jordan Health Corporation	Mary Cariola Children's Center
Aspire of WNY	MC Collaborative
Baden Street Settlement	Monroe County Office of Mental Health/DSS/SPOA/DOH
Baker Hall Inc. dba Baker Victory Services	Monroe Plan for Medical Care, Inc.
Beacon Health Options	MVP Health Care
Berkshire Farm Center for Youth	New Directions Youth & Family
Catholic Charities Community Services	New York Care Coordination Program, Inc
Catholic Family Center	New York State Office of Alcohol & Substance Abuse Svr
Cayuga County Health Department/SPOA/DSS/OMH	New York State Office of Mental Health
Cayuga Counseling Services Inc.	NYSARC Monroe County Chapter
Cayuga Home for Children dba Cayuga Centers	Ontario County Department of Mental Health/DOH/SPOA/DSS
Centene Corporation	Orleans Co Dept of Mental Health/DOH/SPOA/DSS
Chemung County Department of Health/OMH/DSS/SPOA	Pathways, Inc
Children's Health Home of Upstate New York (CHHUNY)	Person Centered Housing Options
Community Care of Rochester, Inc./ Visiting Nurse Signature Care/UR Medicine Home Care	Regional Primary Care Network/Rushville CHC Rochester Regional Health
Coordinated Care Services Inc	Rochester Rehabilitation Center
Delphi Drug and Alcohol Council	Rochester Psychiatric Center
DePaul Community Services	Schuyler County Community Services
East House Corporation	Seneca County Department of Mental Health/DOH/SPOA/DSS
Encompass Health Home—Catholic Charities of Broome County	SPCC Society for Prevention
Epilepsy-Pralid, Inc.	Southern Tier Environments for Living
Excellus Health Plans/Centene/Envolve	Steven Schwarzkopf Community Mental Health Center
Family Services of Chemung County, Inc.	Stuben County Community Mental Health Services/DOH/SPOA/DSS
Fidelis Care	The ARC of Orleans County
Finger Lakes Therapy Works	United Cerebral Palsy of Rochester
Finger Lakes Addictions Counseling and Referral (FLACRA)	United Health Care
Finger Lakes United Cerebral Palsy dba Happiness House	University of Rochester/Strong Memorial Hospital
Gateway- Longview	Venture Forthe, Inc.
Genesee Co. Mental Health/SPOA/DSS/DOH	Villa of Hope
Glove House	Wayne ARC
Greater Rochester Health Home Network (GRHHN)	Wayne County Behavioral Health/DOH/SPOA/DSS
HCR Care Management, LLC	Wyoming County Mental Health/DOH/SPOA/DSS
Health Homes of Upstate New York (HHUNY)	Yates County Department of Community Services/DOH/SPOA/DSS/OMH
Heritage Christian Services	YourCare Health Plan
Hillside Children's Center	YWCA
Huther Doyle Memorial Institute, Inc.	Wellcare
Ibero-American Action League	TruCare
Innovative Care LLC	
John D Kelly Behavioral Health Center	

DETAIL ELIGIBILITY CRITERIA FOR CHILDREN – ATTACHMENT C

Health Home Eligibility Criteria for Children: Medicaid eligible/active Medicaid without any Health Home Program restriction of service **and** two (2) or more chronic conditions **or** one (1) single qualifying condition of either HIV/AIDS or a Serious Emotional Disturbance (SED) or Complex Trauma. In addition to having a qualifying condition, an individual must be assessed and found to meet Appropriateness Criteria, found to have significant behavioral, medical, or social risk factors to deem them appropriate for Health Home Services.

Complex Trauma - Children's Eligibility for Health Home Care Management services on the basis of Complex Trauma is based on three criteria. All three must be present in order for a child to be determined eligible:

1. Complex Trauma Exposure - The child has been exposed to multiple interpersonal traumatic events, or at least one chronic interpersonal trauma lasting 18 months or more (ages 6-21). For young children (ages 0-5) a determination of "chronic" exposure can be made for periods less than 18 months.
2. Functional Impairments - Based on assessment and based on at least one face-to-face interview, the child experiencing functional impairments in at least two of the following categories, or acute impairment in at least one category: Physiology/Neurodevelopment, Emotional Response, Cognitive Processes, Impulse Control/Self-regulation, Self-image, or Relationships with others.
3. Links between Traumatic Exposure and Experience of Functional Impairments: Functional Impairments result from, or are linked to, the Trauma Exposure OR are best explained as being a result of, or exacerbated by, Complex Trauma, and not as the result of some other diagnosis or developmental delay.

Serious Emotional Disturbance (SED), is a Single Qualifying Chronic Condition for Health Home Eligibility - a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders ***AND*** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

- Serious Emotional Disturbance – DSM Qualifying Mental Health Categories can be used when evaluating a child for SED, (however any diagnosis that is secondary to another medical condition is excluded):
  - Schizophrenia Spectrum and Other Psychotic Disorders
  - Bipolar and Related Disorders
  - Depressive Disorders
  - Anxiety Disorders
  - Obsessive-Compulsive and Related Disorders
  - Trauma-and Stressor-Related Disorders
  - Dissociative Disorders
  - Somatic Symptom and Related Disorders
  - Feeding and Eating Disorders
  - Gender Dysphoria
  - Disruptive, Impulse-Control, and Conduct Disorders
  - Personality Disorders
  - Paraphilic Disorders
  - ADHD for children who have utilized any of the following services in the past three years: Psychiatric inpatient, Residential Treatment Facility, Day treatment, Community residence, Mental Health HCBS & OCFS B2H Waiver, OMH Targeted Case Management
- Functional Limitations Requirements - the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:
  - Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
  - Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
  - Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
  - Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
  - Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).