COMMUNITY REFERRAL FOR CARE MANAGEMENT SERVICES

The three local, lead Health Homes: Circare (formerly Onondaga Case Management Services, Inc.); Central New York Health Home Network, Inc. (CNYHHN); and St. Joseph's Care Coordination Network (SJCCN), are accepting referrals for the designation of eligible individuals into care management services. Individuals must meet all eligibility requirements to be considered for enrollment.

CARE MANAGEMENT SERVICES ELIGIBILITY

1. Individual must be 18 or older; AND
2. Individual currently has active Medicaid or Medicaid Managed Care; AND
3. Individual resides in one of the following counties: Cayuga, Lewis, Madison, Oneida, Onondaga, or Oswego; AND
4. Individual meets the NYS DOH eligibility criteria of: one or more chronic conditions; AND
5. Individual 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 the lead Health Homes to verify eligibility for 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 e-mail or fax, or mail to:

Circare **(formerly OCMS, Inc.)** **620 Erie Blvd.** **West, Suite 302** **Syracuse, NY 13204** **Attn: DSRIP At-Risk Referral** **Margaret Fontenot** **mfontenot@cir.care** **Fax: (315) 472 – 0084**	**Central New York** **Health Home Network** **(CNYHHN)** **326 Catherine St.** **Utica, NY 13501** **Attn: Referrals CNYHHN, Inc.** **Jennifer Consiglio** **jennifer.consiglio@cnyhealthhome.net** **Fax: 315-624-9428** **Questions? Call 1-855-784-1262**	**St. Joseph's** **Care Coordination Network** **(SJCCN)** **4888 West Taft Road** **Liverpool, NY 13088** **Attn: DSRIP Coordination Care** **HH Eligibility:** **Daniel.Bocchino@sjhsyr.org** **HH Assignment:** **Alexandra.Butterfield@sjhsyr.org** **Fax: 315-703-2467** **Call: 315-703-2802**

Be sure to include all pages in your submission!

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the person in care management services. Services are voluntary and the individual will be asked to consent during the outreach and engagement process.

Care Management Services

Community Referral Application

Care Management Services for:
Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego Counties

Please provide the following information:

Date of Referral:	**Date of Birth:**	☐ **Male** ☐ **Female**
Individual's Name:		
Address: **City:** **State:** **ZIP:** **County of Residence (check):** ☐ *Cayuga* ☐ *Madison* ☐ *Onondaga* ☐ *Lewis* ☐ *Oneida* ☐ *Oswego*		**Medicaid CIN#:** ***Required to process*** **Medicaid Managed Care Organization Name:** ***if known***
Preferred Care Management Agency (if known): **Best way for Care Manager to contact individual:** Select One **Contact information:**		
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Contact Information for Person Completing Referral

Name:	**Title:**
Organization:	
Phone:	**Email:**

Eligibility 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:*		

Individual's Name:			
Eligibility Information, Continued			
2. Check All That Apply. Selection will assist Lead Health Home determine the level of care management.			
Check	**Eligibility Category**	**Category**	**Specific Diagnosis; Provide Available Detail**
☐	**A**	Serious Mental Illness (disorder must result in functional impairment that substantially interferes with or limits one or more major life activities)	
☐	**B**	HIV/AIDS & the risk of developing another chronic condition	
☐	**C**	Mental Health Condition	
☐	**C**	Substance Abuse Disorder	
☐	**C**	Asthma	
☐	**C**	Diabetes	
☐	**C**	Cardiovascular Disease (including Hypertension)	
☐	**C**	BMI > 25	
☐	**C**	Other Chronic Condition(s) (specify)	

Eligibility Key:
A: Eligible for Health Home Care Management services
B: Eligible for Health Home Care Management services
C: *One Selected*: Eligible for DSRIP Care Management services
Two or More Selected: Eligible for Health Home Care Management services

Consent for Referral	
Check the method of consent for referral to care management services.	
☐	Individual provided verbal consent to be referred to care management services. Date verbal consent received:
☐	Individual signed written consent to be referred. Signed statement is attached to this referral.

Internal Use Only:

Health Home Program

DSRIP Care Management (CNYCC Project 2aiii)

CONSENT TO DISCLOSURE OF HEALTH INFORMATIONFORM
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. 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 HEALTHINFORMATION

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 associated with a Lead Health Home.

4. This information may be disclosed by any person or organization that holds a record described below.

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