CommunityHealth Care Collaborative Health Home at HRHCare ***(CCCHH at HRHCare)***
175 Fulton Avenue Suite 510 Hempstead, NY 11550
Phone: 1-888-980-8410 / Fax: 1-516-506-7160

CARE COORDINATION COMMUNITY REFERRAL | NASSAU COUNTY

Medical, Behavioral Health & Substance Abuse Care Management Services

		Date:
Last Name	**First Name**	**SSN**
Address: Street		Apt.
Town	State	Zip
Alt. Address: Street		Apt.
Town	State	Zip
AKA (also known as):		
Home Phone:	Mobil Phone:	Alt. Phone:
E-mail address:		

DEMOGRAPHIC INFORMATION

DOB: | Age: | Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐ White ☐ Hispanic/Latino ☐ Alaskan Native ☐ Native Hawaiian
☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander
☐ Other, specify:

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Primary Language (spoken at home): ☐ English ☐ Spanish ☐ Other (specify):

Primary Language During Service Provision: ☐ English ☐ Spanish ☐ Other (specify):

If necessary, who will interpret? Hearing Impaired: ☐ Yes ☐ No

ENTITLEMENTS

☐ Medicaid	Medicaid Number:
☐ Medicaid Managed Care	Medicaid Number: Managed Care Provider:
☐ Medicare	Medicare number:
☐ Private Insurance	Insurance Provider:
☐ No Insurance	

REFERRAL SOURCE

☐ Self, family or friend
☐ Mental Health outpatient
☐ Mental Health inpatient
☐ Mental Health residential
☐ Substance Abuse Program
☐ MR/DD Facility
☐ General Hospital ER
☐ General Hospital (inpatient)
☐ Other medical provider
☐ Family Court
☐ Criminal Court
☐ Parole
☐ Probation
☐ Jail, penitentiary, etc.
☐ Other Health Home: specify:

REFERRAL INFORMATION

Name/ Title:		
Agency:		
Email:		
Phone #:		Ext:

Applicant:	Medicaid #

APPLICANT DIAGNOSIS per DSM-V List all diagnoses, including CMI (severe mental illness) personality disorders, and/or developmental disabilities
Mental Health Diagnosis:
Substance Use Disorder Diagnosis:
Other: Specify

ALL MENTAL HEALTH AND SUBTANCE ABUSE PROGRAMS MUST INCLUDE PSYCHOSOCIAL AND PSYCHIATRIC EVALUATIONS

MEDICAL DIAGNOSIS (check all that apply)	
☐ Asthma	☐ Hypertension
☐ Diabetes	☐ Obesity (BMI >25)
☐ Heart Disease	☐ HIV/AIDS
☐ Other, please specify:	

ATTACH AVAILABLE SUPPORTING DOCUMENTATION OF MEDICAL DIAGNOSIS

MENTAL HEALTH/SUBSTANCE ABUSE/MEDICAL PROVIDERS, *if known*	
Outpatient MH Treatment Provider	Name
	Phone
Outpatient Substance Abuse Provider	Name
	Phone
Primary Health Care Provider	Name
	Phone
Other Medical Provider	Name
Specialty:	Phone
Other Medical Provider	Name
Specialty:	Phone

APPROPRIATENESS FOR HEALTH HOME *(Significant behavioral, medical or social risk factors that can be addressed through care coordination)* **CHECK ALL THAT APPLY AND EXPLAIN BELOW**

- ☐ Probable risk for adverse event, e.g., death, disability, inpatient or nursing home admission
- ☐ 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
- ☐ Recent release from incarceration or psychiatric hospitalization
- ☐ Deficits in activities of daily living such as dressing, eating, etc.
- ☐ Learning or cognitive issues

CMA PREFERENCE: (If client has a CMA preference, please indicate below)

- ☐ Central Nassau Guidance & Counseling Services (***CNGC***)
- ☐ Mental Health Association (***MHA***)
- ☐ Economic Opportunity Counsel (***EOC***)
- ☐ Office of Mental Health (***OMH***)
- ☐ Long Island Association for AIDS Care (***LIAAC***)
- ☐ Options for Community Living (***OPTIONS***)
- ☐ Long Island Federally Qualified Health Center (***LIFQHC***)

*Referrals with an SMI/SUD diagnosis will be re-routed to the Nassau County LGU SPOA for review

CommunityHealth Care Collaborative (CCC) at HRHCare
Health Home Referral Form - Patient Consent

I agree that _____, the "Referring Agency" may disclose my name, address, telephone number, email address and _____ _____ to Hudson River HealthCare (HRHCare) to allow HRHCare to (I) determine if I am eligible to receive care management services from the HRHCare Health Home and (II) contact me about these services if I am eligible.
I understand that the information disclosed to HRHCare may include (I) information related to HIV/AIDS, (II) records of any treatment I have recieved from licensed mental health facilities or programs and (III) records of any treatment I have recieved from federally assisted alcohol or drug abuse treatement facilities or programs.

My consent will be valid for one year from the date I sign this form.

I understand that:
(1) I may withdraw this consent in writing at any time, except to the extent Referring Agency has already taken action in reliance on this consent.
(2) This consent is voluntary and Referring Agency may not condition treatment on my willingness to sign this consent.
(3) I have a right to a signed copy of this consent.
(4) Any information disclosed under this consent may be re-disclosed by HRHCare only as permitted by applicable state and federal law.

I have read and fully understand this consent form. By signing below, I authorize Referring Agency to disclose information about me consistent with the terms of this consent.

Name of Patient: _____

By: _____ Date: _____
Signature of Individual or Personal Representative

Basis of Personal Representative's Authority (if applicable): _____

FOR CCC/HRHCARE USE ONLY:

Date/Time Received: _____ Staff Receiving: _____

CCA Referred to: _____ Staff at CCA Contacted: _____

Date of CCA Contact _____ Date of Referral Source Contact: _____