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CommunityHealth Care Collaborative (CCC) at HRHCare

Health Home Referral Form

CCC is a NYS Department of Health designated Health Home (HH). Our program provides community based care coordination services for high-need Medicaid recipients (FFS and Managed Care). Each HH member has a dedicated Care Coordinator responsible for managing an individualized care plan, including communicating with the providers that serve their assigned HH members. Active Medicaid recipients are eligible for the HH based on clinical diagnosis and functional status. Diagnostic criteria include the following:

- ☐ One Serious Mental Illness (SMI); and/or,
- ☐ HIV/AIDS; and/or,
- ☐ Two chronic conditions: mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, other chronic conditions.

In order to apply for Health Home services please complete this referral form, patient consent and diagnostic information and fax to 914-606-3328. HH eligibles will be directly contacted by CCC with information on their designated Care Coordinator, and a disposition report will be provided to the referring agency.

Date: _____ Referring Provider/Agency: _____

Contact Person: _____ Phone/email: _____

Applicant Name: _____ Date of Birth: _____ Medicaid CIN: _____

Gender: M/F Managed Care Plan (if applicable):_____

Home Phone: _____Cell Phone: _____Email: _____

Address (Street, City, Zip): _____ County of Residence: _____

Emergency Contact (Name and Phone Number): _____

Primary Care Provider Name/Agency/Phone (if applicable): _____

Does patient speak English?Y/N Primary language: _____ Hearing impaired?Y/N

A. Please check all diagnoses that apply and attach documentation of diagnoses as available (continued on following page):

☐ **Serious Mental Health Condition**
- ☐ Bi-Polar Disorder
- ☐ Schizophrenia
- ☐ Recurrent Major Depressive Disorder
- ☐ Other: _____

☐ Submitted a SPOA application (if applicable).

☐ **HIV/AIDS**

☐ **Two Chronic Conditions (see below)**

Physical Health Conditions	Mental Health Conditions	Substance Use Disorders
☐ Advanced Coronary Artery Disease	☐ Conduct, Impulse Control, and Other Disruptive Behavior Disorders	☐ Chronic Alcohol Abuse
☐ Cerebrovascular Disease	☐ Dementia in conditions classified elsewhere	☐ Alcohol Liver Disease
☐ Congestive Heart Failure	☐ Depressive and Other Psychoses	☐ Cocaine Abuse
☐ Hypertension	☐ Eating Disorder	☐ Drug Abuse – Cannabis/NOS/NEC
☐ Peripheral Vascular Disease	☐ Major Personality Disorders	☐ Substance Abuse
☐ BMI over 25	☐ Unspecified Non-psychotic Psychiatric Disease (Except Schizophrenia)	☐ Opioid Abuse
☐ Chronic Renal Failure	☐ OTHER: _____	☐ OTHER: _____
☐ Diabetes		
☐ Asthma		
☐ Chronic Obstructive Pulmonary Disease		
☐ OTHER: _____		

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B. Please check any categories below that pertain to the applicant being referred:

Poor Connectivity to Care

- ☐ No primary care provider
- ☐ No connection to specialty doctor or other practitioner
- ☐ Difficulty with compliance (does not keep appointments, non-adherence to medications, etc)
- ☐ Inappropriate Emergency Department use (3+ in a 12 months)
- ☐ Repeated recent hospitalizations for preventable conditions (medical or psychiatric — 2+ in 12 months)
- ☐ Recent release from incarceration
- ☐ Homelessness
- ☐ Cannot be effectively treated in an appropriately resourced patient centered medical home

Other Significant Behavioral, Medical, or Social Risk Factors

- ☐ Recent discharge from psychiatric hospitalization
- ☐ Probable risk for an adverse event
- ☐ Lack of or inadequate social, family, or housing support
- ☐ Deficits in activities of daily living
- ☐ Learning or cognition issues

☐ Other (please specify): _____

Please attach any additional pertinent information about the individual, including other known provider relationships, current existing care management, recent hospitalizations, current medications (medical or psychiatric) etc.

C. Please indicate the top three preferences for a care coordination agency:

☐ **No Preference** (CCC will assign based on geography and patient need)

Please select the top three agency preferences or select "No Preference"

Columbia

- ☐ Alliance for Positive Health
- ☐ Catholic Charities
- ☐ Columbia County Dept. of Human Services
- ☐ Greene County Mental Health

Dutchess

- ☐ Hudson Valley Community Services
- ☐ Hudson River HealthCare
- ☐ Mental Health America of Dutchess

Greene

- ☐ Alliance for Positive Health
- ☐ Catholic Charities
- ☐ Greene County Mental Health
- ☐ Mental Health Association of Columbia/Greene

Orange

- ☐ Access: Support for Living
- ☐ Cornerstone Family Health Care
- ☐ HONORehg
- ☐ Hudson Valley Community Services
- ☐ Mental Health Association of Orange
- ☐ Rehabilitation Support Services

Putnam

- ☐ Hudson Valley Community Services
- ☐ Putnam Family & Community Services

Rockland

- ☐ Hudson Valley Community Services
- ☐ Hudson River HealthCare
- ☐ Jawonio
- ☐ Mental Health Association of Rockland

Sullivan

- ☐ Hudson Valley Community Services
- ☐ Rehabilitation Support Services
- ☐ Sullivan Co. Dept. of Community Mental Health

Westchester

- ☐ Choice of New Rochelle
- ☐ Hudson Valley Community Services
- ☐ Hudson River HealthCare
- ☐ Human Development Services of Westchester
- ☐ Mental Health Association of Westchester
- ☐ Phelps Memorial Hospital
- ☐ St. John's Riverside Hospital
- ☐ St. Joseph's Medical Center
- ☐ St. Vincent's Hospital
- ☐ The Guidance Center of Westchester
- ☐ Westchester Jewish Community Services

If you have any questions, please call CCC/HRHCare at 1-888-980-8410.

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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 HRHC 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 received from licensed mental health facilities or programs and (iii) records of any treatment I have received from federally assisted alcohol or drug abuse treatment 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: _____

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