CommunityHealth Care Collaborative
Children's 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 who is responsible for managing an individualized care plan, including communicating with the providers that serve his/her assigned HH member. Active Medicaid recipients are eligible for the HH based on clinical diagnosis and functional status. Diagnostic criteria include the following:

- ☐ Severe Emotional Disturbance (SED) and/or Complex Trauma; HIV/AIDS; and/or,
- ☐ Two chronic conditions: mental health condition, substance use disorder, asthma, diabetes, heart disease, other chronic conditions.

In order to refer a child for HH services, please complete this form and fax to 914-606-3328, ATTN: HHSC.

The parent(s) of each HH eligible child will be directly contacted by CCC's subcontracted care management agency ("CMA") assigned to the child with information on the child's designated Care Coordinator; the Care Coordinator will directly contact the parent(s) as well.

Date:_____ Referring Provider/Agency: _____

Contact Person:_____ Phone/email:_____

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

Parent/Legal Guardian Name: _____ Parent Medicaid CIN: _____

Gender: M / F Does the parent receive HH services? Y/N If yes, from which agency: _____

Home Phone:_____ Cell Phone:_____ Email:_____

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

Emergency Contact (Name and Phone Number): _____

Primary Care Provider Name/Agency/Phone (ifapplicable): _____

Does patient speak English? Y / N Primary language:_____ Is the child hearing impaired? Y / N

A. Please check all diagnoses that apply and attach documentation of diagnoses as available (continued on following page): Note: You may only may release the child's health information about services the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services with the child's consent.

☐ **Single Qualifying Conditions**
- ☐ SED
- ☐ Complex Trauma
- ☐ HIV/AIDS

☐ Submitted a SPOA application (if applicable).

☐ **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	☐ Opioid Abuse
☐ Chronic Renal Failure	☐ Psychiatric Disease (Except Schizophrenia)	☐ OTHER: _____
☐ Diabetes	☐ OTHER: _____	
☐ Asthma		
☐ Chronic Obstructive Pulmonary Disease		
☐ OTHER:		

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 (medical or psychiatric) for preventable conditions (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, patient need, among other factors)

Columbia
Access: Supports for Living
Columbia County Dept. of Human Services
St. Anne Institute

Dutchess
Access: Supports for Living
AFEC Services, LLC
Mental Health America of Dutchess
Rehabilitation Support Services
St. Anne Institute

Greene
Access: Supports for Living
Greene County Community Services Board
St. Anne Institute

Nassau
EAC
Family and Children's Association
Long Island Association for AIDS Care
Options for Community Living
St. Mary's Healthcare System

Orange
Access: Supports for Living
AFEC Services, LLC
Cornerstone Family Healthcare
HONORehg
Rehabilitation Support Services
Rockland Children's Psychiatric Center
St. Anne Institute

Putnam
Access: Supports for Living
AFEC Services, LLC
Open Door Family Medical Center
Putnam Family & Community Services
St. Anne Institute

Rockland
Access: Supports for Living
AFEC Services, LLC
Mental Health Association of Rockland
Rockland Children's Psychiatric Center
St. Anne Institute

Suffolk
Angela's House
Association for Mental Health and Wellness
Family and Children's Association
Family Service League
Long Island Association for AIDS Care
Options for Community Living
Promoting Specialized Care and Health
St. Mary's Healthcare System
Suffolk County Dept. of Mental Health Hygiene

Sullivan
Access: Supports for Living
AFEC Services. LLC
Rehabilitation Support Services, Inc.
Rockland Children's Psychiatric Center
St. Anne Institute
Sullivan County Dept. of Community Services

Westchester
Access: Supports for Living
AFEC Services, LLC
Hudson River HealthCare, Inc.
Mental Health Association of Westchester
Open Door Family Medical Center
St. Anne Institute
The Guidance Center of Westchester
Westchester Jewish Community Services

If you have any questions, please call the Health Home Hotline at CCC/HRHCare at 1-888-980-8410, SELECT OPTION "4".

CommunityHealth Care Collaborative (CCC)

Health Home Referral Form – Parental Consent

I agree that _____, the "Referring Agency" may disclose (i) my name, address, telephone number, email address and (ii) diagnosis and other health information ("Child's Information") regarding my child, listed below, ("Child") so that the Referring Agency can make a referral to CCC to allow CCC to determine if Child is eligible for enrollment in CCC children's health home.

If CCC determines that Child is eligible for the children's health home then I agree that CCC may release Child's Information to one or more of its subcontracted care management agencies ("CMA") which will provide Child with care management services, and I understand the CMA will contact Child and me about these services to assist with Child's enrollment. A list of CMAs is provided on Attachment A.

I understand that my child's Information disclosed to CCC may include (i) HIV/AIDS related information, (ii) records of any treatment Child has received from licensed mental health facilities or programs and (iii) records of any treatment Child has received from federally assisted alcohol or drug abuse treatment facilities or programs. I understand that Child's Information will not include any information about services that Child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. Child would need to provide consent to release that information.

I authorize CCC to disclose Child's Information, including the information listed in (i)-(iii) above, to the CMA to which Child is assigned.

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

In addition to the above, 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 Child's treatment on my willingness to sign this consent.

(3) I have a right to a signed copy of this consent.

(4) Child's Information disclosed under this consent may be re-disclosed by CCC only as permitted by applicable state and federal law, EXCEPT that I understand that if Child is eligible for enrollment in the children's health home, CCC will re-disclose Child's Information to the CMA to which Child is assigned. Child Information will be re-disclosed by CCC 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 refer my Child to CCC and to disclose Child's Information consistent with the terms of this consent.

Child:_____

Parent/Legal Guardian Name/Relationship: _____

Parent/Legal Guardian Signature: _____

_____

Date: _____

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