CommunityHealth Care Collaborative (CCC) at Hudson River HealthCare
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 (i.e. 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 for members in the Hudson Valley, or 845-765-9383 for members in Long Island. Members who are eligible for services will be directly contacted by CCC with information on their designated Care Coordinator, and the referring agency will receive follow-up. If you have any questions, please call CCC at 1-888-980-8410.

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

If this is a criminal justice referral, please select the applicable category: ☐ Probation ☐ Parole ☐ Prison

Please describe the member's criminal history, if applicable: ____

Please enter the member's DIN number, if available: ____________________

A. Please check all diagnoses that apply and attach documentation of diagnoses as available:

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

☐ **HIV/AIDS**

☐ **Chronic Conditions (see below for common chronic conditions)**

Physical Health Conditions	Mental Health Conditions	Substance Use Disorders
☐ Advanced Coronary Artery Disease ☐ Cerebrovascular Disease ☐ Congestive Heart Failure ☐ Hypertension ☐ Peripheral Vascular Disease ☐ BMI over 25 ☐ Chronic Renal Failure ☐ Diabetes ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease ☐ OTHER: ____________________	☐ Conduct, Impulse Control, and Other Disruptive Behavior Disorders Dementia in conditions classified elsewhere ☐ Depressive and Other Psychoses ☐ Eating Disorder ☐ Major Personality Disorders ☐ Unspecified Non-psychotic Psychiatric Disease (Except Schizophrenia) OTHER: __________________	☐ Chronic Alcohol Abuse ☐ Alcohol Liver Disease ☐ Cocaine Abuse ☐ Drug Abuse – Cannabis/NOS/NEC ☐ Substance Abuse ☐ Opioid Abuse ☐ 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 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 circle the top three preferences for a care management agency or select "No Preference."

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

Columbia & Greene
Alliance for Positive Health
Catholic Charities
Columbia County Dept. of Human Services (Columbia Only)
Greene County Mental Health (Greene Only)
Mental Health Association of Columbia/Greene

Dutchess
Hudson Valley Community Services
Hudson River Health Care
Mental Health America of Dutchess

Nassau
Central Nassau Guidance
EAC Network
EOC of Suffolk
Hudson River Health Care
Long Island FQHC
Mental Health Association of Nassau
New Horizon Counseling Center
Options for Community Living

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

Putnam
CoveCare Center
Hudson Valley Community Services

Rockland
Hudson Valley Community Services
Hudson River Health Care
Jawonio
Mental Health Association of Rockland
Refuah Health Center

Suffolk
Association for Mental Health & Wellness
EAC Network
EOC of Suffolk
Family Service League
Federation of Organizations
Hudson River Health Care
New Horizon Counseling Center
Options for Community Living
WellLife Network
Sayville Project

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 Health Care
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

CommunityHealth Care Collaborative (CCC) at Hudson River HealthCare
Health Home Referral Form - 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 the 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 the 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): _______________________________