



## Community Health 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.**

**OR use this online referral link:** <https://www.cognitofrms.com/CCHealthHome/cccommunityreferral>

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 (if applicable): \_\_\_\_\_

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

**Dutchess**

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

**Greene**

Access: Supports for Living

**Nassau**

EAC  
Family and Children's Association  
Options for Community Living

**Orange**

Access: Supports for Living  
AFEC Services, LLC  
HONORehg  
Rehabilitation Support Services  
Rockland Children's Psychiatric Center  
St. Dominic's Family Services

**Putnam**

Access: Supports for Living  
AFEC Services, LLC  
CoveCare Center  
Open Door Family Medical Center

**Rockland**

Access: Supports for Living  
AFEC Services, LLC  
Blythedale Children's Hospital  
Mental Health Association of Rockland  
Rockland Children's Psychiatric Center  
St. Dominic's Family Services

**Suffolk**

Angela's House  
Association for Mental Health and Wellness  
Family and Children's Association  
Family Service League  
Options for Community Living  
Promoting Specialized Care and Health  
Suffolk County Dept. of Mental Health Hygiene

**Sullivan**

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

**Westchester**

Access: Supports for Living  
AFEC Services, LLC  
Blythedale Children's Hospital  
Hudson River HealthCare, Inc.  
Mental Health Association of Westchester  
Open Door Family Medical Center  
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".

**Community Health 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): \_\_\_\_\_