



Health Homes of Upstate New York

Alcohol & Drug Dependency Services — Beacon Health Strategies
Chautauqua County Department of Mental Hygiene — Huther Doyle Memorial Institute
New York Care Coordination Program — Onondaga Case Management Services

REFERRAL FOR HEALTH HOME SERVICES

Health Homes of Upstate New York (HHUNY) is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible individuals into HHUNY Health Home Services. The HHUNY Health Home is a care management service model whereby all of the professionals involved in a members' care communicate with one another so that all needs (medical, behavioral and health and social service) are addressed in a comprehensive manner.

Health Home Services Eligibility Requirements

1. Individual currently has active Medicaid; AND;
2. Individual resides in one of the following Counties: Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Cortland, Erie, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario, Orleans, Oswego, Schuyler, Seneca, Steuben, Tompkins, Tioga, Wayne, or Yates County; AND;
3. Individual meets the NYS DOH eligibility criteria of: two chronic conditions and/or HIV/AIDS and the risk of developing another chronic condition and/or one or more serious mental illnesses; AND;
4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management.

Health Home Services

The member will be assigned to a dedicated Care Manger and will receive the following services:

1. Comprehensive Care Management: Development and implementation of a comprehensive individualized person-centered care plan with goals and interventions to meet identified needs.
2. Care Coordination and Health Promotion: Management of the Plan of Care, ensuring coordination of all aspects of the member's care and communication among all involved in such care.
3. Comprehensive Transitional Care: Active involvement in all phases of care transition, including discharge planning, assuring follow-up care linkage and re-engagement of those lost to care.
4. Patient and Family Support: A Plan of Care that reflects and incorporates the patient, family or caregiver preferences and includes education and support for self-management, self-help recovery, peer support and other resources as appropriate.
5. Referral to Community and Social Support Services: Identification of available community-based resources to meet the member's needs and active management of referrals, engagement and coordination via the plan of care.

HHUNY Health Home Community Referral Application

Please complete the attached Community Referral Application Form, including as much detail as possible to allow HHUNY to verify eligibility for health home services. In addition, please include a brief narrative including any additional information that may be helpful in assignment to a care management agency. If there is a care management agency that is preferred by the individual, please identify the agency.

The signed Consent to Release Information must be attached.

Upon HHUNY approval of this application, the individual will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the person in health home services. Health Home services are voluntary and the individual will be asked to consent during the outreach and engagement process.

Completed applications may be sent via secure e-mail, Fax or mail to:

HHUNY Community Referral Representative

Email: tracy.marchese@beaconhs.com

Fax: 585-613-7670

Mail: Community Referral Specialist

Health Homes of Upstate New York

1099 Jay Street, Bldg. J

Rochester, NY 14611

If you have questions regarding the completion or status of this application, please contact:

HHUNY Community Referral Representative at 585-613-7642

HHUNY Health Home Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	Cell phone:	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

Eligibility Category Information – Check All that Apply Must meet either A only or B only or two C to be eligible

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness	
	B	HIV/AIDS and the risk of developing another chronic condition	
	C	Mental Health condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

Risk Factors - Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	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	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	

Narrative

Provide any additional information that may be helpful in assignment to a care management agency:

Specify Preferred or Recommended Care Management Agency, if any: _____

Contact Information for Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email: