# MONROE COUNTY COMMUNITY REFERRAL FOR CARE MANAGEMENT

Community Referrals for Health Home Care Management for Medicaid and dual eligible Medicaid/Medicare persons and Mental Health and/or Substance Use (Behavioral Health) Care Management for persons not Medicaid eligible and/or not eligible for Health Home Care Management are now being accepted in Monroe County from providers, community organizations, individuals and/or family members.

- Health Home Care Management is being provided by Greater Rochester Health Home Network (GRHHN) AND Health Homes of Upstate New York – Finger Lakes (HHUNY-Finger Lakes) for eligible Medicaid and Medicaid/Medicare dual eligible persons.
- Behavioral Health Care Management is being triaged through the Monroe County Office of Mental Health for individuals with mental health and/or chronic substance abuse disorders who are not eligible for Health Home Care Management.

**Individuals must meet all eligibility requirements to be considered for enrollment. Please check the type of care management the person qualifies for:**

| ☐ **Behavioral Health Care Management** | ☐ **Health Home Care Management** |
|---|---|
| ☐ 1. Individual is not eligible for Health Home Care Management services because:<br>• Individual is not eligible for Medicaid; **OR**<br>• Individual does not meet DOH eligibility criteria; **AND** | ☐ 1. Individual meets the NYS DOH eligibility criteria of:<br>• two chronic conditions, **OR**<br>• HIV/AIDS and the risk of developing another chronic condition **OR**,<br>• one or more serious mental illnesses; **AND** |
| ☐ 2. Individual has a mental health and/or chronic substance use disorder; AND | ☐ 2. Individual currently has active Medicaid or Medicaid and Medicare; |
| ☐ 3. Individual resides in Monroe County AND | ☐ 3. Individual resides or receives services in Monroe County; AND |
| ☐ 4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management. | ☐ 4. Individual has significant behavioral, medical or social risk factors which can be addressed through care management. |

## How to Make a Care Management Referral:

1. Complete the attached Referral Application Form, including as much detail as possible to allow the Health Homes and Monroe County Office of Mental Health / Single Point of Access (SPOA) to determine eligibility.
2. Attach a signed "Consent to Disclosure of Health Information" Form
3. Send completed application and Consent via secure e-mail or fax, or mail to ONE of the following:

| **BEHAVIORAL HEALTH CARE MANAGEMENT** | **HEALTH HOME CARE MANAGEMENT: HEALTH HOMES** | |
|---|---|---|
| **Monroe County Office of Mental Health Priority Services** | **GRHHN:**<br>Greater Rochester Health Home<br>**Greater Rochester Health Home Network** | **HHUNY:**<br>**Health Homes of Upstate New York: Finger Lakes** |
| Lisa Babbitt<br>lbabbitt@monroecounty.gov<br>Phone: (585) 753-2874<br>Fax: (585) 753-2885 or (585) 753-5015<br>Mail: Monroe County SPOA<br>80 West Main St., 4th Floor<br>Rochester, NY 14614 | Deb Peartree<br>grhhn@direct.rrhio.org<br>Phone: 585-737-7522<br>Fax: 585-423-2806<br>Mail: Greater Rochester Health Home Network, Referral.<br>82 Holland Street<br>Rochester, NY 14605 | Tracy Marchese<br>tracy.marchese@beaconhs.com<br>Phone: 585-613-7642<br>Fax: 585-613-7670<br>Mail: Community Referral<br>Health Homes of Upstate NY<br>1099 Jay Street, Bldg. J<br>Rochester, NY 14611 |

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and engage the person in care management services. Care Management services are voluntary and the individual will be asked to consent during the outreach and engagement process.

**Community Referral Application**

**Identifying Information**

| | | |
|---|---|---|
| Name: | Date of Birth: | Gender: |
| Address: | Medicaid CIN #: | |
| | Medicaid Managed Care Organization Name: | |
| | County of Residence: | |
| Phone: | E-Mail: | |
| Alternative Contact(s) Name, 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 Cs to be eligible for Health Home Care Management**

| Check | | Category | Specify Diagnosis; Provide Available Detail |
|---|---|---|---|
| | A | Serious mental illness | |
| | B | HIV/AIDS & 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) | |

List Current Medical or Behavioral Health Treatment Providers, if Known:

_____

_____

**Care Management Needs - Check All that Apply**

| Check | Category | Explain Factor and Care Management Need |
|---|---|---|
| | Probable risk for adverse event | |
| | Repeated ER/Inpatient Use, Including Avoidable ER Use | |

| | | |
|---|---|---|
| | 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 | |
| | Financial Needs | |

**Risk and Safety Concerns – Check all That Apply**

| Check | Concern | | Check | Concern |
|---|---|---|---|---|
| | Suicidal Ideation | | | History of Suicide Attempts |
| | Homicidal Ideation | | | History of Violence |
| | Active Substance Abuse | | | Unsafe Living Environment |
| | Other – Specify | | | |

Provide additional information regarding Risk and Safety Concerns checked above.

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| |

**Narrative**

Provide any additional information that may be helpful in assignment to a care management agency. If known, include strengths and/or interests of the referred individual

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| |

**Specify Preferred or Recommended Care Management Agency (check one):**

| | |
|---|---|
| | More Behavioral Health - Strong Ties |
| | More Medical - Visiting Nurse Signature Care |
| | Other:_____ |

**Contact Information for Person Completing Referral:**

| | |
|---|---|
| Name: | Title: |
| Organization: | |
| Phone: | Email: |

## Permission to Use and Disclose Confidential Information

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with care management and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of care management services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

## Consent to disclosure of health information

The person whose information may be used or disclosed is:

Name: _____.

Date of Birth: _____.

1. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
2. This information may be disclosed to the persons or organizations listed in Attachment A.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
4. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
5. This permission expires on _____ (date).
6. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship _____.)

I give permission to use and disclose my records as described in this document.

_____ _____

Signature Date

**CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A**

Health information may be disclosed for purposes of treatment to the organizations listed below. The following organizations provide and/or administer Care Management in Monroe County:

- Anthony L. Jordan Health Corporation
- Beacon Healthcare Strategies, LLC
- Behavioral Health Network (Rochester General Hospital)
- Catholic Charities Community Services
- Catholic Family Center
- Community Care of Rochester, Inc. DBA Visiting Nurse Signature
- Coordinated Care Services, Inc.
- Delphi Drug and Alcohol Council
- DePaul Community Services
- East House Corporation
- Epilepsy-Pralid, Inc.
- Finger Lakes Addictions Counseling and Referral (FLACRA)
- Greater Rochester Health Home Network (GRHHN)
- Health Homes of Upstate New York (HHUNY)
- Hillside Children's Center
- Huther Doyle Memorial Institute, Inc.
- Ibero-American Action League
- Jefferson Family Medicine
- L. Woerner, Inc. (dba HCR)
- Lifespan of Greater Rochester
- Monroe County Office of Mental Health
- Monroe Plan for Medical Care, Inc.
- New York Care Coordination Program, Inc.
- Rehabilitation Counseling & Assessment Services, LLC.
- Rochester General Health System
- Rochester Rehabilitation Center
- Steven Schwarzkopf Community Mental Health Center
- Trillium Health
- Unity Health System
- University of Rochester/Strong Memorial Hospital
- Villa of Hope
- YWCA