

**COMMUNITY REFERRAL**  
**FOR NYS HEALTH HOME CARE MANAGEMENT SERVICES FOR ADULTS**

CNYHHN, Inc. is accepting referrals from the community for enrollment of eligible adults into Health Home Services.  
Adults must meet all eligibility requirements to be considered for enrollment.

**HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY**

1. Adult currently has active Medicaid or Medicaid Managed Care; AND,
2. Adult resides in one of the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence;  
AND,
3. Adult meets the NYS Department of Health Eligibility Criteria:
  - 2 or more chronic medical or mental health conditions (See List of Chronic Conditions), or
  - HIV/AIDS, or
  - Sickle Cell Disease, or
  - one or more serious mental illness; AND,
4. Adult has significant behavioral, medical, or social risk factors which can be addressed through care management.

**HOW TO MAKE A REFERRAL**

1. Complete the attached Community Referral Application Form.
2. Please make sure the Medicaid CIN Number is on the referral (this is two letters, followed by five numbers, and one letter) **Example: (AA12345A)**.
3. Eligibility Category Information: Make sure to specify the diagnosis: **Example: (Serious mental illness – 296.8 Bipolar Disorder NOS; Example: Other Chronic Conditions – COPD)**.
4. Risk Factor – Give some detailed information concerning member's risk factors: **Example: (Member is at risk for hospitalization due to non-adherence with medication)**.
5. No Referral can be processed without the member's consent form, which is included in the Referral. **Referral will not be processed without a consent per DOH; this can include noted verbal consent.** CONSENT TO DISCLOSURE OF HEALTH INFORMATION from CNYHHN Referral is needed.
6. If you are an agency assisting a member in completing a self-referral, make sure to list your contact information along with the member's information, as the Referral Coordinator may not be able to reach the member, which delays the referral process.
7. If Referrals are coming from an inpatient unit, please provide:
  - **Name of hospital and contact information for the Discharge Planner**
  - **Admission and planned discharge date**
  - **Reason for admission**
8. Send the completed application and consent via secure email or fax, or mail to:

CNYHHN, Inc.  
268 Genesee Street, Suite 202  
Utica, NY 13502

[Referrals@cnyhealthhome.net](mailto:Referrals@cnyhealthhome.net)

Fax: 315-624-9428

Questions? Call 1-855-784-1262

**Be sure to include all pages in your submission!**

Approved Adults will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the Adult in Health Home Care Management Services. Health Home services are voluntary and the Adult will be asked to consent during the outreach and engagement process.

## Adult Community Referral Application

Health Home Care Management Services

**PLEASE ATTACH SUPPORTING DOCUMENTATION, DIAGNOSIS AND SIGNED CONSENT  
IN ORDER TO EXPEDITE THIS REFERRAL**

### PLEASE PROVIDE THE FOLLOWING INFORMATION

Date of Referral:	Date of Birth:	Gender:	Medicaid CIN#: <i>Required to process</i>
Name:			
Address:		Medicaid Managed Care Organization Name ( <i>if known</i> ):	
County of Residence: <i>Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida or St. Lawrence</i>		Social Security# if CIN unavailable:	
Best way for care manager to contact:			
Indicate any need for language/interpretation services; specify language spoken if other than English:			
Specify Preferred or Recommended Care Management Agency, if any: Why are you selecting this Agency?			

### CONTACT INFORMATION FOR PERSON COMPLETING REFERRAL

Name:	Title:
Organization:	
Phone:	Email:
Is referral from an embedded site (Yes or No)?	If yes, which site?

### ELIGIBILITY INFORMATION

1. Does Individual have significant behavioral, medical, or social risk factors which can be addressed through care management? Check all that apply

<input type="checkbox"/> Probable risk for adverse event, e.g. death, disability, or nursing home admission	<input type="checkbox"/> Lack of, or inadequate connectivity with healthcare
<input type="checkbox"/> Learning or cognition issues	<input type="checkbox"/> Recent release from inpatient setting
<input type="checkbox"/> Deficits in activities of daily living such as dressing, eating, etc.	<input type="checkbox"/> Non-adherence to treatments or medication(s), or difficulty managing medications
<input type="checkbox"/> Other ( <i>please describe</i> ):	

<b>Name:</b>
<b>ELIGIBILITY INFORMATION (CONTINUED)</b>
1. Does Individual have ONE single qualifying condition of a Serious Mental Illness, Sickle Cell Disease, or HIV/AIDS, or TWO or more chronic conditions? Check all that apply
<b>SINGLE QUALIFYING CONDITION</b>
<b>Serious Mental Illness</b>
<b>HIV/AIDS</b>
<b>Sickle Cell Disease</b>
<b>OR, 2 OR MORE CHRONIC CONDITIONS: please check at least 2 on list below</b>

## Health Home Chronic Conditions, in alphabetical order

Acquired Hemiplegia and Diplegia
Acquired Paraplegia
Acquired Quadriplegia
Acute Lymphoid Leukemia w/wo Remission
Acute Non-Lymphoid Leukemia w/wo Remission
Alcoholic Liver Disease
Alcoholic Polyneuropathy
Alzheimer's Disease and Other Dementias
Angina and Ischemic Heart Disease
Anomalies of Kidney or Urinary Tract
Apert's Syndrome
Aplastic Anemia/Red Blood Cell Aplasia
Ascites and Portal Hypertension
Asthma
Atrial Fibrillation
Attention Deficit / Hyperactivity Disorder
Benign Prostatic Hyperplasia
Bi-Polar Disorder
Blind Loop and Short Bowel Syndrome
Blindness or Vision Loss
Bone Malignancy
Bone Transplant Status
Brain and Central Nervous System Malignancies
Breast Malignancy
Burns - Extreme
Cardiac Device Status
Cardiac Dysrhythmia and Conduction Disorders
Cardiomyopathy
Cardiovascular Diagnoses requiring ongoing evaluation and treatment
Cataracts
Cerebrovascular Disease w or w/o Infarction or Intracranial Hemorrhage
Chromosomal Anomalies
Chronic Alcohol Abuse and Dependency
Chronic Bronchitis
Chronic Disorders of Arteries and Veins
Chronic Ear Diagnoses except Hearing Loss
Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses
Chronic Eye Diagnoses
Chronic Gastrointestinal Diagnoses
Chronic Genitourinary Diagnoses

Chronic Gynecological Diagnoses
Chronic Hearing Loss
Chronic Hematological and Immune Diagnoses
Chronic Infections Except Tuberculosis
Chronic Joint and Musculoskeletal Diagnoses
Chronic Lymphoid Leukemia w/wo Remission
Chronic Metabolic and Endocrine Diagnoses
Chronic Neuromuscular and Other Neurological Diagnoses
Chronic Non-Lymphoid Leukemia w/wo Remission
Chronic Obstructive Pulmonary Disease and Bronchiectasis
Chronic Pain
Chronic Pancreatic and/or Liver Disorders (Including Chronic Viral Hepatitis)
Chronic Pulmonary Diagnoses
Chronic Renal Failure
Chronic Skin Ulcer
Chronic Stress and Anxiety Diagnoses
Chronic Thyroid Disease
Chronic Ulcers
Cirrhosis of the Liver
Cleft Lip and/or Palate
Coagulation Disorders
Cocaine Abuse
Colon Malignancy
Complex Cyanotic and Major Cardiac Septal Anomalies
Conduct, Impulse Control, and Other Disruptive Behavior Disorders
Congestive Heart Failure
Connective Tissue Disease and Vasculitis
Coronary Atherosclerosis
Coronary Graft Atherosclerosis
Crystal Arthropathy
Curvature or Anomaly of the Spine
Cystic Fibrosis
Defibrillator Status
Dementing Disease
Depression
Depressive and Other Psychoses
Developmental Language Disorder
Developmental Delay NOS/NEC/Mixed
Diabetes w/wo Complications
Digestive Malignancy

<b>NAME:</b>	
Disc Disease and Other Chronic Back Diagnoses w/wo Myelopathy	
Diverticulitis	
Drug Abuse Related Diagnoses	
Ear, Nose, and Throat Malignancies	
Eating Disorder	
Endometriosis and Other Significant Chronic Gynecological Diagnoses	
Enterostomy Status	
Epilepsy	
Esophageal Malignancy	
Extrapyramidal Diagnoses	
Extreme Prematurity - Birthweight NOS	
Fitting Artificial Arm or Leg	
Gait Abnormalities	
Gallbladder Disease	
Gastrointestinal Anomalies	
Gastrostomy Status	
Genitourinary Malignancy	
Genitourinary Stoma Status	
Glaucoma	
Gynecological Malignancies	
Hemophilia Factor VIII/IX	
History of Coronary Artery Bypass Graft	
History of Hip Fracture Age > 64 Years	
History of Major Spinal Procedure	
History of Transient Ischemic Attack	
HIV Disease	
Hodgkin's Lymphoma	
Hydrocephalus, Encephalopathy, and Other Brain Anomalies	
Hyperlipidemia	
Hypertension	
Hyperthyroid Disease	
Immune and Leukocyte Disorders	
Inflammatory Bowel Disease	
Intestinal Stoma Status	
Joint Replacement	
Kaposi's Sarcoma	
Kidney Malignancy	
Leg Varicosities with Ulcers or Inflammation	
Liver Malignancy	
Lung Malignancy	
Macular Degeneration	
Major Anomalies of the Kidney and Urinary Tract	
Major Congenital Bone, Cartilage, and Muscle Diagnoses	
Major Congenital Heart Diagnoses Except Valvular	
Major Liver Disease except Alcoholic	
Major Organ Transplant Status	
Major Personality Disorders	
Major Respiratory Anomalies	
Malfunction Coronary Bypass Graft	
Malignancy NOS/NEC	
Mechanical Complication of Cardiac Devices, Implants/Grafts	
Melanoma	

Migraine
Multiple Myeloma w/wo Remission
Multiple Sclerosis and Other Progressive Neurological Diagnoses
Neoplasm of Uncertain Behavior
Nephritis
Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's
Neurofibromatosis
Neurogenic Bladder
Neurologic Neglect Syndrome
Neutropenia and Agranulocytosis
Non-Hodgkin's Lymphoma
Obesity (BMI at or above 25 for adults and BMI at or above the 85th percentile)
Opioid Abuse
Osteoarthritis
Osteoporosis
Other Chronic Ear, Nose, and Throat Diagnoses
Other Malignancies
Pancreatic Malignancy
Pelvis, Hip, and Femur Deformities
Peripheral Nerve Diagnoses
Peripheral Vascular Disease
Persistent Vegetative State
Phenylketonuria
Pituitary and Metabolic Diagnoses
Plasma Protein Malignancy
Post-Traumatic Stress Disorder
Postural and Other Major Spinal Anomalies
Prematurity - Birthweight < 1000 Grams
Progressive Muscular Dystrophy and Spinal Muscular Atrophy
Prostate Disease and Benign Neoplasms – Male
Prostate Malignancy
Psoriasis
Psychiatric Disease (except Schizophrenia)
Pulmonary Hypertension
Recurrent Urinary Tract Infections
Reduction and Other Major Brain Anomalies
Rheumatoid Arthritis
Schizophrenia
Secondary Malignancy
Secondary Tuberculosis
Sickle Cell Anemia
Significant Amputation w/wo Bone Disease
Significant Skin and Subcutaneous Tissue Diagnoses
Spina Bifida w/wo Hydrocephalus
Spinal Stenosis
Spondyloarthropathy and Other Inflammatory Arthropathies
Stomach Malignancy
Tracheostomy Status
Valvular Disorders
Vasculitis
Ventricular Shunt Status
Vesicostomy Status
Vesicoureteral Reflux

**CONSENT TO DISCLOSURE OF HEALTH INFORMATION FORM  
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 medical treatment and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of healthcare 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. However, 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**

1. The person whose information may be used or disclosed is:  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
2. 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.
3. This information may be disclosed to the persons or organizations listed in Attachment A.
4. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
5. 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.
6. This permission expires on \_\_\_\_\_ (date).
7. 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, parent, or guardian, please enter relationship \_\_\_\_\_) I give permission to use and disclose my records as described in this document.

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Signature

Date

**CONSENT TO DISCLOSURE OF HEALTH RECORDS– ATTACHMENT A  
CNYHHN, INC.**

Health information may be disclosed for purposes of treatment to the people and organizations listed below:

<b>Cayuga County</b>
<ul style="list-style-type: none"> <li>• CNYHHN, Inc. Care Management</li> <li>• Salvation Army</li> </ul>
<b>Herkimer County</b>
<ul style="list-style-type: none"> <li>• ACR Health</li> <li>• Building Blocks</li> <li>• CNYHHN, Inc. Care Management</li> <li>• Helio Health</li> <li>• ICAN</li> <li>• Salvation Army</li> <li>• The Neighborhood Center</li> <li>• Upstate Cerebral Palsy Care Management</li> </ul>
<b>Jefferson County</b>
<ul style="list-style-type: none"> <li>• ACR Health</li> <li>• Bridging the Gap Care Management</li> <li>• Children’s Home/Care Coordination of Northern New York</li> <li>• CREDO Community Center</li> <li>• HCR Health Care Management, LLC</li> <li>• Mental Health Association in Jefferson Co.</li> <li>• Transitional Living Services of NNY</li> </ul>
<b>Lewis County</b>
<ul style="list-style-type: none"> <li>• ACR Health</li> <li>• Bridging the Gap Care Management</li> <li>• Children’s Home/Care Coordination of Northern New York</li> <li>• CREDO Community Center</li> <li>• HCR Health Care Management</li> <li>• Transitional Living Services of NNY</li> </ul>
<b>Madison County</b>
<ul style="list-style-type: none"> <li>• ACR Health</li> <li>• Building Blocks</li> <li>• CNYHHN, Inc. Care Management</li> <li>• Helio Health</li> <li>• ICAN</li> <li>• Salvation Army</li> </ul>

**Oneida County**

- ACR Health
- Building Blocks, LLC
- CNYHHN, Inc. Care Management
- Helio Health
- ICAN
- The Neighborhood Center, Inc.
- Presbyterian Residential Community
- Salvation Army

**St. Lawrence County**

- ACR Health
- Bridging the Gap Care Management
- Children's Home/Care Coordination of Northern New York
- HCR Health Care Management, LLC
- Mental Health Association in Jefferson Co.
- St. Lawrence County Community Services
- Transitional Living Services of NNY
- United Helpers Mosaic