Children's Health Home of Upstate New York
Family Driven Care Management Services

COMMUNITY REFERRAL FOR HEALTH HOME CARE MANAGEMENT SERVICES

The Children's Health Home of Upstate New York (CHHUNY) is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible children/youth into Health Home Care Management Services. Children/youth must meet all eligibility requirements to be considered for enrollment.

Health Home Care Management Services Eligibility:

1. Child/youth currently has active Medicaid;
   AND
2. Child/youth resides in one of the following Counties:
   Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saint Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates
   AND
3. Child/youth meets the NYS DOH eligibility criteria of:
   a. two chronic conditions, or
   b. HIV/AIDS, or
   c. complex trauma or,
   d. serious emotional disturbance
   e. HCBS eligible

   AND
4. Child/youth has significant behavioral, medical or social risk factors which can be addressed through care management.

How to Make a Referral to CHHUNY

1. Complete the attached Community Referral Application Form, including as much detail as possible to allow CHHUNY to verify eligibility for health home care management services.
2. You may return the completed Application directly to a CHHUNY Care Management Agency, or to CHHUNY via secure e-mail, fax, or mail:

   Email: Referrals@ChildrensHealthHome.org
   Fax: 866-243-8662
   Mail: CHHUNY Community Referral Coordinators
   Health Homes of Upstate New York
   1099 Jay Street, Bldg. J, 3rd floor
   Rochester, NY 14611

Approved children/youth will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the child/youth in health home care management services. Health Home services are voluntary and the youth and/or parent/guardian will be asked to consent during the outreach and engagement process.

If you have questions regarding the completion or status of this application, please contact: CHHUNY Community Referral Coordinator at 855-209-1142.

CHHUNY Health Home Community Referral Application

Identifying Information

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

Foster Care:

Is the child currently in Foster Care? ☐ Yes ☐ No ☐ Unknown	If a child is currently in Foster Care, only the Local Department of Social Services (LDSS) may complete the referral, which must be completed by them in the Medicaid Analytics & Performance Portal (MAPP)

Consent to Refer:

Consent to make this referral must be obtained from the parent/guardian/legally authorized representative for children up until the age of 18. For children/youth ages 18-21, or that are married, a parent, or pregnant may provide consent on their own behalf. Who has provided you with consent to make this referral to CHHUNY?

☐ Parent ☐ Guardian ☐ Legally Authorize Representative

☐ Child/Youth who is (circle one): 18 years or older A parent Pregnant Married

Consenter Information:

(Please provide the following information about the person you received consent from to make this referral

First Name:	Last Name:
Relationship to Child/Youth:	Telephone Number:

Parent Health Home Connectivity:

Is the child/youth's parent or guardian currently enrolled in the Health Home Program?

☐ No ☐ Yes

Note: If the child/youth's parent or guardian is not currently enrolled in the Health Home program, if you or they believe that the parent/guardian is eligible and the parent/guardian is interested you can complete a referral for Adult Health Home Services. If the parent or guardian lives in western, finger lakes, or the central regions Health Homes of Upstate New York (HHUNY) may be able to serve him or her. Navigate to www.hhuny.org to complete the adult health home referral. If outside of these regions, you can refer to other Adult Health Homes by reaching out to health homes certified to serve his or her county by navigating to https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/

Contact Information for Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email:
☐ Yes ☐ No As the referral source, are you able to provide proof of eligibility?	
☐ Yes ☐ No Are you referring the child in order to be assessed for HCBS?	

Preventive Services Connectivity:

Is the child/youth currently receiving preventive services?

☐ No ☐ Yes (please specify provider name and NPI if known): _____

Child/Youth Inpatient Status:

Is the child/youth current admitted to an inpatient facility?

☐ No ☐ Yes

If yes, what is the name of the facility? _____ Expected discharge Date?_____

Eligibility Category Information *(if ICD-10 code(s) are available please include them)*

☐ **Two or more Chronic Conditions** (examples include: asthma, substance use disorder, diabetes, cerebral palsy, sickle cell anemia, cystic fibrosis, epilepsy, spina bifida, congenital heart problems, etc.)

- List Qualifying Chronic Conditions: _____

OR

☐ **Serious Emotional Disturbance (SED):** ***single qualifying condition***

SED is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostical and Statistical Manual (DSM) categories (Schizophrenia Spectrum and Other Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders, Anxiety Disorders, Obsessive-Compulsive and Related Disorders, Trauma-and Stressor-Related Disorders, Dissociative Disorders, Somatic Symptom and Related Disorders, Feeding and Eating Disorders, Gender Dysphoria, Disruptive, Impulse-Control, and Conduct Disorders, Personality Disorders, Paraphilic Disorders, ADHD, Elimination Disorders, Sleep Wake Disorders, Sexual Dysfunctions, Medication Induced Movement Disorders, and Tic Disorder) as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); OR
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); OR
- Social relationships (e.g. establishing and maintaining friendship; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); OR
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgement and value systems; decision-making ability; OR
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)

OR

☐ **Complex Trauma:** ***single qualifying condition***

Note – If this is the only box checked on the form you must ALSO complete the <u>Complex Trauma Referral Cover Sheet</u> and the <u>Complex Trauma Exposure</u> Screen and attach with the referral form.

Definition of Complex Trauma:

a. The term complex trauma incorporates at least:
   a. Infants/children/or adolescents' exposure multiple traumatic events, often of an invasive, interpersonal nature, and
   b. The wide-ranging, long-term impact of this exposure
b. The nature of the traumatic events:
   a. Often is severe and pervasive, such as abuse or profound neglect;
   b. Usually begins early in life;
   c. Can be disruptive of the child's development and the formation of a health sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
   d. Often occur in the context of the child's relationship with a caregiver; and
   e. Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for health social-emotional functioning.
c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability
d. Wide-ranging, long-term adverse effects can include impairments in:
   a. Physiological responses and related neurodevelopment,
   b. Emotional responses,
   c. Cognitive processes including the ability to think, learn, and concentrate,
   d. Impulse control and other self-regulating behavior,
   e. Self-image, and
   f. Relationships with others.

OR

☐ **HIV/AIDS:** ***single qualifying condition***

☐ **HCBS/LOC Referral**

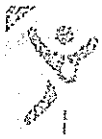
Risk Factors - Check All that Apply and Provide Explanation of How Child/Youth Exhibits Risk Factors

☐ **At risk for adverse event** *(e.g. death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement);* ☐ **Has inadequate social/family/housing support, or serious disruptions in family relationships;** ☐ **Has inadequate connectivity with healthcare system;** ☐ **Does not adhere to treatments or has difficulty managing medications;** ☐ **Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;** ☐ **Has deficits in activities of daily living, learning or cognition issues; OR** ☐ **Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home**	

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: _____



Children's Health Home of Upstate New York

Serious Emotional Disturbance (SED) Verification Form

Name: _____ Date of Birth: _____ Medicaid CIN: _____

Select at least one DSM Qualifying Mental Health Category*:	Current Diagnosis: (ICD-10)
☐ Anxiety Disorders	
☐ Bipolar and Related Disorders	
☐ Depressive Disorders	
☐ Disruptive, Impulse-Control, and Conduct Disorders	
☐ Dissociative Disorders	
☐ Obsessive-Compulsive and Related Disorders	
☐ Feeding and Eating Disorders	
☐ Gender Dysphoria	
☐ Paraphilic Disorders	
☐ Personality Disorders	
☐ Schizophrenia Spectrum and Other Psychotic Disorders	
☐ Somatic Symptom and Related Disorders	
☐ Trauma- and Stressor-Related Disorders	
☐ ADHD for children who meet the functional criteria for SED and have utilized any of the following services in the past three years:	
☐ Psychiatric inpatient	Please include dates of service and name of program/facility:
☐ Residential Treatment Facility	
☐ Day treatment	
☐ Community residence	
☐ Mental Health HCBS & OCFS B2H Waiver	
☐ OMH Targeted Case Management	

**Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.*

Functional Limitation(s): (Select all that apply & severity, must have at least 2 moderate or 1 severe to qualify)	Moderate	Severe
☐ Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries)		
☐ Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting)		
☐ Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time)		
☐ Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability)		
☐ Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school)		

☐ I hereby attest, as a Licensed Mental Health Professional that this child/youth meets the clinical standards for Health Home SED determination as indicated above.

Name of Licensed Professional: _____

Organization: _____

Licensed Professional Signature: _____

Date: _____

Additional Comments (if needed):

Children's Single Point of Access Application Part 1 **Child's Name:**_____
DOB:_____

Children's SPOA includes several agencies that collaborate to provide the best possible support for children and their families. The following is a check list of agencies that the parent agrees for exchanging information with SPOA, check "ALL" or all that apply:

- ☐ ALL LISTED
- ☐ Tioga County Children's Single Point of Accessibility (SPOA) – Coordinator & Family Partner
- ☐ Tioga County Mental Hygiene
- ☐ Aspire Hope NY
- ☐ Berkshire Farms and Berkshire Farms Care Management
- ☐ Chemung County Family Services Care Management/Sexually Acting Out Youth (SAY)
- ☐ Comprehensive Psychiatric Emergency Program (CPEP)
- ☐ Elmcrest Children's Center
- ☐ Hillside Children's Center Regional Permanency Resource Centers
- ☐ Hillside Stillwater Care Management
- ☐ Glove House Mental Health Respite/ Community Residence Respite/Care Management
- ☐ Tioga County Probation Department
- ☐ Greater Binghamton Health Center Outpatient/Inpatient
- ☐ Liberty Resources Multi-Systemic Therapy (MST)
- ☐ Tioga County Department of Social Services CPS/FAR/Preventive/Pins Diversion
- ☐ Office of People w/Developmental Disabilities/LifePlan CCO
- ☐ Elmira Psychiatric Center Inpatient/Health Home Care Management
- ☐ Pathways Health Home Care Management/CFTSS/HCBS/Conable House Community Residence
- ☐ Racker Care Management
- ☐ Robert Packer Behavioral Unit
- ☐ Wyoming Conference Day Treatment/Care management/CFTSS/Tioga County Youth Assertive Community Treatment (ACT)
- ☐ NYS Office of Mental Health Pre-Admission Certification Committee (PACC)
- ☐ Child's School District_____
- ☐ _____
- ☐ _____

I also agree to my child's information to be entered into the NYS MAPP Portal System in order to request an agencies support for my child.

*_____	*_____	*_____
Signature of Parent or Legal Guardian	**Printed Name**	**Date**
*_____	*_____	*_____
Signature of Witness	**Printed Name of Witness**	**Date**