Mental Health America of Dutchess County

Completed referrals must be submitted with supporting clinical documentation of child's diagnosis.

**Please indicate type of supporting document below:**

- ☐ Comprehensive Mental Health Assessment
- ☐ Psychosocial Assessment
- ☐ Psychiatric Assessment
- ☐ SED Verification Form
- ☐ Verification from Primary Care Provider
- ☐ Other (specify):_____

# Children's Health Home Referral Form

MHA of Dutchess County is a NYS Department of Health designated Health Home Care Management Provider. 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.

**To refer a child for HH services, complete this form and return (with supporting documentation) to:**

**CODY GONZALEZ, MA, HHSC Program Manager**

**Email: cgonzalez@mhadutchess.org**
**OR Fax: (845) 473-4870**
**OR Mail/drop off: 253 Mansion St. Poughkeeepsie, NY 12601**

Date:_____Referring Provider/Agency: _____

Contact Person:_____Phone/email:_____

Applicant Name:_____Date of Birth:_____**Medicaid CIN**: _____

Parent/Legal Guardian Name: _____Parent Medicaid CIN: _____

Gender: _____ Does parent receive HH services? Y/N If yes, 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 DIAGNOSIS AS AVAILABLE:**
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 SPOA Application (if applicable)

☐ **Two Chronic Conditions (see below)**

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

# CommunityHealth 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:

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.

This consent is voluntary, and Referring Agency may not condition Child's treatment on my willingness tosign this consent.

I have a right to a signed copy of this consent.

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):