Children's Health Home Program

Christine M. Burns CARES Center

Community Referral for Health Home Care Management Services

The Golisano Children's Hospital Health Home Care Management Agency is accepting referrals from the community for enrollment of eligible children/youth up to age 21 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 Monroe County;
   AND
3. Child/youth meets NY State DOH eligibility criteria of:
   a) Two chronic conditions, or
   b) HIV/AIDS, or
   c) Complex Trauma, or
   d) Serious Emotional Disturbance
   e) HCBS eligible, or
   f) Sickle Cell
   AND
4. Child/youth has significant behavioral, medical, developmental, or social risk factors which can be addressed through care management.

How to make a Referral to Golisano Children's Health Home Program

Complete the attached community referral applications form. Please include as much detail as possible to allow Golisano Children's Hospital Health Home to verify eligibility for health home care management services.
You may return the completed application directly to Golisano Children's Hospital Health Home Care Management agency via secure fax, mail, or a scanned email to:

Email: CHHReferrals@URMC.Rochester.edu
Fax: (585) 742-4228
Mail: Golisano Children's Health Home
601 Elmwood Avenue, Box 777
Rochester NY14642

Approved referrals will receive 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 our main number at **(585) 275-4242.**

Identifying Information:

Child's Name:	Date of Birth:	Gender:
Current Address:	Medicaid CIN #:	
	Medicaid MCO 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: *Please note that non-VFCAs can create a segment for a child in foster care through the Children's Referral Portal in MAPP after consultation with LDSS.*

Is the child currently in Foster Care? ☐ Yes ☐ No ☐ Unknown	**For LDSS use ONLY** LDSS County: _____ LDSS Contact Name: _____ Phone Number: _____

Consent to Refer:

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

☐ Parent ☐ Guardian ☐ Legally Authorized Representative

☐ Child/youth who is (select 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/hh_map/index.htm

Contact Information for Person Completing Referral:

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

Preventative Services Connectivity:

Is the child/youth currently receiving preventative services?

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

Child/Youth Inpatient Status:

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

☐ No ☐ Yes

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

Eligibility Category Information

Please select the presumptive eligibility category in which the child may qualify for Health Home services.

☐ **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, intellectual developmental disability, etc.)

Please List Qualifying Chronic Conditions & ICD-10 Codes: _____

_____

OR

☐ **Serious Emotional Disturbance (SED):** *Single Qualifying Condition*

NOTE: If this is the only box checked on this form, you must **ALSO** complete the Serious Emotional Disturbance Verification Form and attach with the referral form.

An SED is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostically 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:

Please provide the applicable diagnosis(es): _____

Please indicate which functional limitations are applicable:

- ☐ 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 friendships; 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 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 this form, you must **ALSO** complete the Complex Trauma Referral Cover Sheet, Complex Trauma Exposure Screen and attach with the Referral Form Packet.

Definition of Complex Trauma:

a) The term complex trauma incorporates at least:
   1. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
   2. The wide-ranging, long-term impact of this exposure

b) The nature of the traumatic events:
   1. Often is severe and pervasive, such as abuse or profound neglect.
   2. Usually begins early in life;
   3. Can be disruptive to the child's development and the formation of a health sense of self (with self-regulatory, executive functioning, self-perceptions, etc.).
   4. Often occur in the context of the child's relationship with a caregiver; and
   5. Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for health and 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:
   1. Physiological responses and related neurodevelopment,
   2. Emotional responses,
   3. Cognitive processes including the ability to think, learn and concentrate,
   4. Impulse control and other self-regulating behavior,
   5. Self-image, and
   6. Relationships with others.

OR

☐ **HIV/AIDS:** *Single Qualifying Condition*

☐ **Sickle Cell:** *Single Qualifying Condition*

OR

☐ **HCBS/LOC Referral**

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

Adverse Events Risk:

☐ Member currently involved with mandated preventative services. Must specify date issued services and provider of service: *Required Explanation*:_____

Member had recent inpatient/ED/psychiatric hospital/Detox within the last 6 months. Must specify name of institution and date of release. *Required Explanation*: _____

☐ Member recently out of home placement (foster care, relative, RTF, RTC, etc.) within the last 6 months. Must specify name of institution and date of release. *Required Explanation:* _____

☐ Member recently diagnosed with a terminal illness/condition within the last 6 months. Must specify condition and the date diagnosed. *Required Explanation*:_____

☐ Member received an initial Disability Determination (SSI or DOH Disability Certificate/letter) within the last 6 months. *Required Explanation:*_____

☐ Released from jail, prison/juvenile detention, involved with probation, PINS, family court within the last 6 months. Must specify name of program and date of release/court/probation. *Required Explanation:*_____

Healthcare Risk:

☐ Member (or guardian) is unable to appropriately navigate the healthcare system for the member's chronic conditions.

☐ Member does not have a healthcare provider or specialist to treat a chronic health condition.

☐ Member has not seen their provider (e.g., PCP, BH, etc.) in the last year.

Social Determinants Risk:

☐ Current intimate partner violence/current family violence in the home of the member.

☐ Currently cannot access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.

☐ Currently homeless (HUD 1, 2, OR 4) & for transitional age youth, has no stable living arrangement (living with different friends/family)

☐ Member has fewer than 2 people identified as a support by the member.

☐ Member had a change in guardianship/caregiver within the last 6 months.

☐ Member is concurrently HH appropriate due to caregiver/guardian enrolled in HH.

☐ Member (or caregiver if member is a child) does not have needed benefits (SSI, SNAP, etc.).

Treatment Non-Adherence Risk:

☐ Member/care team member report of non-adherence? Must specify WHICH medication(s) and/or treatment(s) are involved. *Required Explanation*:_____

☐ PSYCKES flag related to non-adherence or equivalent from RHIO or MCO.

☐ Direct referral from Managed Care Organization (MCO)

☐ Direct referral from Child Protective Services/ Preventive Services Program.

Narrative: Please provide any additional information that may be helpful.