St. Mary's Health Care
Health Home Serving Child Referral (0-21)
Fax: 518-770-7511
E-Mail: HealthHome@nysmha.org

Thank you for your referral to St. Mary's HealthCare Health Home. To process and assign members in a timely manner, the referral must contain the following but not limited to:

- ✓ A complete and most up to date referral
- ✓ Most recent medical evaluation, psychosocial evaluation, or psychiatric evaluation that outlines the current diagnosis that will be used to determine qualifying criteria into the health home.
- ✓ Signed and attached Consent for Disclosure of Health Information Form

***** PLEASE NOTE THAT INCOMPLETE REFERRALS OR REFERRALS MISSING THE REQUIRED SUPPORTING DOCUMENTATION WILL BE RETURNED TO THE REFERRAL SOURCE AND MAY DELAY PROCESSING FOR ENROLLMENT**********

Name:	DOB:	Phone Number:
Address:		
Language Preference: ☐ English ☐ Spanish ☐ Other : _____		
Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Unknown		

Insurance: Individual must have active Medicaid to be eligible for Health Home	
Medicaid CIN:	Social Security Number
Medicaid Managed Care Organization Name: ☐ Fidelis ☐ CDPHP ☐ Other _____	
County of Residence: ☐ Fulton ☐ Montgomery ☐ ☐ Other: _____	

Please indicate from whom you obtained consent to refer a child to the health home:
☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Member if over 18
☐ Member if under 18 but is a parent, pregnant, or married
Date Permission was obtained: _____
**** A written signature is needed in order to obtain supporting documentation needed to meet eligibility criteria for the health home program.

Medical Consenter Name: _____ Relationship to Child: _____

Address: _____ Phone Number: _____
Foster Care: Yes or No Is Consenter enrolled with Adult Health Home: Yes or No

Eligibility Criteria: MUST attach supporting documentation to referral for criteria used to determine eligibility for enrollment to the Health Home Program

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

Eligibility Criteria: ☐	2 Chronic Medical Conditions
	OR
☐	Single Qualifying Serious Mental Illness- Attachment A is required for SED
☐	HIV/AIDS
☐	Sickle Cell
☐	Complex Trauma- Please reach out to Health Home for additional Referral requirements if no other qualifying condition exists

ICD CODE	Diagnosis	Name of Supporting Documentation Attached
1.		
2.		
3.		
4.		
5.		
6.		

Advance Directives in place, if Yes please attach: ☐ Yes ☐ No ☐ Unknown

Considerations for Health Home Eligibility: Please check all that apply:

☐ At risk for adverse event (i.e. death disability, inpatient or nursing home admission, mandated preventive services, etc.)	☐ Recently released from incarceration or psychiatric hospitalization
☐ Lack of or inadequate social/family/housing support	☐ Recent hospitalization for preventable conditions
☐ Lack of or inadequate connectivity with healthcare system	☐ Recent and repeated ED visits for preventable or PCP managed conditions
☐ Does not adhere to or has sifficulty managing treatment and medications	☐ Deficits in activities of daily living, learning, or cognition issues

Additional Information

Current Living Situation: ☐ Homeless ☐ Stable Housing ☐ Risk of Homelessness
Recent Incarceration: ☐ Yes/ Date of Discharge:_____ ☐ No
Recent psychiatric hospitalization: ☐ Yes/ Date of Discharge:_____ ☐ No
Recent substance abuse hospitalizations: ☐ Yes/Date of Discharge: _____ ☐ No

Please provide a detailed reason for the referral

Referral Source:

Referral organization:
Type of organization i.e.. Hospital, MCO, Specialist, Mental Health Provider etc.
Person making referral/title:
Phone Number:
Email:

_____ _____

Signature Date

Functional Limitation Requirements for SED (Serious Emotional Disturbance)

The Functional Limitations must be **moderate in at least two of the following areas** or **severe in at least one** of following areas as determined by a Licensed Mental Health Professional:

Name: _____ DOB: _____ SED Dx: _____

Functional Limitation	Moderate (at least 2 areas)	Severe (at least one area)
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, relationship 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)		

Please be sure to include the assessment in which the corresponding functional limitations are identified

_____

Signature of Licensed Mental Health Professional **Credential** **Date**

CONSENT TO THE DISCLOSURE OF SUPPORTING DOCUMENTATION FORM
PERMISSION TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION FOR THE USE OF CARE COORDINATION ASSIGNMENT

By signing this Consent Form, you permit parties completing a referral on your behalf to share your health information so that your Health Home can have a complete picture of your health and help connect you to better care. Your health records provide information to determine your eligibility for the Health Home program. Your health records provide information about your illnesses, injuries, diagnoses, medication and/or test results. Your records may include sensitive information.

If you permit disclosure, your health information will be used to assist in Care Coordination related to your health and social services needs. 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 use 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 to the SMH Health Home Program will not be the basis for denial of health services or health insurance. Your choice to give or deny consent is solely for the purpose of obtaining supporting documentation to determine eligibility for the Health Home Program. If you choose not to consent into the Health Home program after a referral has been submitted on your behalf, the Health Home Program is not required to return this information or remove it from their records. You are entitled to a copy of this consent form after you sign it.

CONSENT TO THE DISCLOSURE OF SUPPORTING DOCUMENTATION

1. The person whose information may be used or disclosed is:

   Name: _____Date of Birth: _____

2. The information included in the supporting documentation that will be disclosed to the Health Home Program is for the purpose of determining eligibility for Health Home services and ongoing care coordination. The information that will be disclosed includes records of diagnosis and health care treatment, which could include but not limited to, Mental Health records, Substance Use Treatment records, HIV related information, Genetic information, and information about sexually transmitted diseases.
3. This information will be disclosed to the Care Management Agency (CMA) in which you are assigned to receive Care Coordination services. St Mary's Healthcare Health Home works with Alliance for Positive Health, Building Blocks, Catholic Charities Care Coordination Services, St. Anne Institute, St. Mary's Care Management Agency, and Salvation Army.
4. Use and disclosure of this information is permitted only as necessary for the purposes of Care Coordination Services including outreach, referrals, individualized care planning and monitoring of the quality of service.
5. I understand that I can choose not to pursue Care Coordination services at any time. I also understand that records disclosed with this "Consent to the Disclosure of Supporting Documentation" may not be retrieved. Any person or organization that relied on the supporting documentation may continue to use or disclose that information as needed to complete services.

I authorize the use and disclose of my personal information as described in this document and consent to the referral to the St. Mary's Healthcare Health Home Program.

_____ _____
Signature of Individual/Parent/ Guardian/Legally Authorized Representative Date

_____
Relationship to Referred Member

Health Home Serving Children Serious Emotional Disturbance (SED) Definition

For Health Home Serving Children, SED is a single qualifying chronic condition and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories below* 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.
*SED Definition for Health Home - DSM Qualifying Mental Health Categories**

- 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
- Sleep-Wake Disorders
- Medication-Induced Movement Disorders
- ADHD
- Elimination Disorders
- Sexual Dysfunctions
- Tic Disorder

*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 Limitations Requirements for SED Definition of Health Home

The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas as determined by a licensed mental health professional:

- 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 of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment 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).

Reference:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_elig_appr_prior_6core.pdf