MENTAL HEALTH ASSOCIATION
of COLUMBIA-GREENE COUNTIES, INC.

713 Union Street, Hudson, NY 12534 * ph: 518-828-4619*fx: 518-828-1196

Health Home Referral Form

A Health Home is a program by the New York State Department of Health to facilitate access to a multi-disciplinary array of services and supports for high-need Medicaid recipients with chronic medical and/or behavioral health conditions. The goal of the Health Home is to assure that members receive appropriate access to medical, behavioral and social services in an integrated manner. A Care Manager, whose primary role is to oversee the coordination of a member's care and to focus on health promotion, is assigned to each individual.

Applicants must have active Medicaid coverage in order to be enrolled in the Health Home and meet one of the following diagnostic criteria:

- **One serious Mental Illness (SMI); and/or,**
- **HIV/AIDS and the risk of developing another chronic condition; and/or,**
- **Two chronic conditions: mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, other chronic conditions.**

In order to apply for Health Home services, please complete this referral form. The attached consent is preferred, but not required.

Date: _____

Referring Provider/Agency: _____

Contact Person: _____

Contact Phone/email: _____

Applicant Name: _____ Applicant Date of Birth: _____

Medicaid CIN: _____ Managed Care Plan (If applicable): _____

Social Security #: _____ Gender: _____

Home Phone #: _____ Cell Phone #: _____

Home Address (#, Street, City, State, Zip Code) _____

Emergency Contact Name/Phone #: _____

Health Home Referral Form

A. Please check all diagnosis that apply to the applicant being referred:

Mental Health Condition

- ☐ 296.80 Bi-Polar Disorder
- ☐ 312.0 Conduct, Impulse Control, and other Disruptive Behavior Disorders
- ☐ 294.1 Dementia in conditions classified elsewhere
- ☐ 298.0 Depressive and other Psychoses
- ☐ 307.50 Eating Disorder
- ☐ 301.0 Major Personality Disorders
- ☐ 300.9 Unspecified Non-psychotic Psychiatric Disease (Except Schizophrenia)
- ☐ 295.0 Schizophrenia
- ☐ Other (include diagnostic code): _____

Substance Use Disorders

- ☐ 571.2 Alcohol Liver Disease
- ☐ 291.1 Chronic Alcohol Abuse
- ☐ 305.6 Cocaine Abuse
- ☐ 305.2 Drug Abuse – Cannabis/NOS/NEC
- ☐ 305.9 Substance Abuse
- ☐ 305.5 Opioid Abuse
- ☐ Other (include diagnostic code): _____

Physical Health Conditions

- ☐ 42.0 HIV Disease
- ☐ 414.0 Advanced Coronary Artery Disease
- ☐ 437.9 Cerebrovascular Disease
- ☐ 428.0 Congestive Heart Failure
- ☐ 401.9 Hypertension
- ☐ 443.9 Peripheral Vascular Disease
- ☐ BMI over 25
- ☐ 585.0 Chronic Renal Failure
- ☐ 250.0 Diabetes
- ☐ 493.0 Asthma
- ☐ 496.0 Chronic Obstructive Pulmonary Disease
- ☐ Other (include diagnostic code): _____

Health Home Referral Form

B. Please check any categories below that pertain to the applicant being referred:

- ☐ No primary care provider
- ☐ No connection to specialty doctor or other practitioner
- ☐ Difficulty with compliance (does not keep appointments, etc.)
- ☐ Inappropriate Emergency Department use
- ☐ Repeated recent hospitalizations for preventable conditions (medical or psychiatric)
- ☐ Recent release from incarceration
- ☐ Cannot be effectively treated in an appropriately resourced patient centered medical home
- ☐ Homelessness
- ☐ Other (please specify): _____

Please indicate any additional pertinent information regarding applicant: _____

_____

_____

_____

_____

If you have any questions, please call the Mental Health Association of Columbia-Greene Counties, Inc. @ 518-828-4619 x301 or Care Coordinators Art Birth @ 518-947-6239 or Phil Jackson @ 518-947-6253.

GREENE COUNTY MENTAL HEALTH CENTER
905 Greene County Office Building
Cairo, NY 12413
Ph. 518-622-9163 Fax; 518-622-8592

PART I
AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I, _____ _____the undersigned, hereby consent and
(Client Name) (DOB)
authorize the Greene County Mental Health Center to exchange information with:

_____

_____

(Name, address and phone/fax number of person/organization/facility /program)

Consent to Release Information Extent or Nature of Information to be Disclosed

[ ] Presence in treatment
[ ] Diagnosis, prognosis, treatment status
[ ] Psychological/social assessments
[ ] School records
[ ] Special Education records/IEP
[ ] Treatment plans
[ ] Discharge summary
[ ] Evaluation results
[ ] Medical records
[ ] Other: _____

Purpose of Need for Information

☐To gather information to complete an assessment
☐To allow on-going communication
☐For advocacy purposes
☐To communicate with family/concerned others.
☐To provide ongoing treatment/aftercare
☐To complete an alcohol/drug evaluation
☐For coordination of treatment planning
☐ Other: _____

A. **I hereby permit the use or disclosure of the above information to the person/organization/facility /program identified above. I understand that:**

- Only this information may be used and/or discussed as a result of this authorization
- This information is confidential and cannot be legally disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected by Federal or State Law.
- I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided by Greene County Mental Health Center. I am aware that my revocation will not be effective if the person(s) I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will affect my eligibility for benefits.
- I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy regulation under 45CFR Sec. 164.524
- I understand that any disclosure of information and/or documentation is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of this information and/or documentation to a party other than the one(s) designated above is forbidden without additional written authorization on my part.

B1. One Time Use and/or Disclosure I hereby permit the one-time use or disclosure of the information described above. This authorization will expire: [ ] When acted upon [ ] 90 days from today's date_____ [ ] Upon termination from clinical services

B2. Periodic Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the above named as often as necessary to fulfill the purpose identified above. My authorization will expire:
[ ] When I am no longer receiving services [ ] One year from today's date_____ [ ] Other:_____

_____ _____
Patient's Name (printed) Signature of Patient or Parent/Guardian

I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

_____ _____
Staff Person's Name and Title Date