Creating Hope, Transforming Lives
Catholic Charities
DIOCESE OF SYRACUSE
Onondaga County

Health Home Care Management Services/ HH+ Intensive Care Management
Referral Form

HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY

1. Individual currently has active Medicaid, AND
2. Individual meets the NYS DOH eligibility criteria of: two chronic conditions, or HIV/AIDS or, one or more serious mental illnesses, AND
3. Individual has significant behavioral, medical or social risk factors that can be addressed through care management.

HOW TO MAKE A REFERRAL TO CCOC

1. Complete the attached Community Referral Application Form, including as much detail as possible to allow Catholic Charities of Onondaga County to verify eligibility for health home care management services.
2. Attached a signed "Consent to Disclosure of Health Information" Forms; if you are able to provide proof of the diagnosis/diagnoses, please include this with the application
3. Send the completed Application and Consents via secure e-mail or fax to:

   Catholic Charities Intake Coordinator: Cassandra Knight

   Email: healthhomereferrals@ccoc.us

   Fax: 315-410-5336

Note: Health home services are voluntary and the individual will be asked to consent during the outreach and engagement process.

REFERRAL SOURCE INFORMATION

Name of Person Referring:	Date of Referral:
Referring Agency's Name:	Referring Program/Department:
Person Referring's Phone Number:	Person Referring's Email:
Indicate any need for language/interpretation services; specify language spoken if other than English:	

IDENTIFYING INFORMATION OF PERSON BEING REFERRED-*Required Fields

*Name:	Date of Birth:	
*Address:	*Medicaid CIN #: CIN has 8 characters total - 2 letters, 5 numbers, 1 letter If CIN unavailable, provide SS #	
	*County of Residence:	Gender:
*Phone:	*Social Security Number:	Age:

Preferred Language:

ELIGIBILITY CATEGORY INFORMATION

Check All that Apply. **Must meet either A only or B only or two C to be eligible**

Check		Category	Specify Diagnosis; Provide Available Detail
	A	Serious mental illness	
	B	HIV/AIDS & the risk of developing another chronic condition	
	C	Mental Health conditions	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

RISK FACTORS- *Answers may indicate eligibility for HH+ level programming. All clients are screened for HH+ eligibility at enrollment.

Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	*Homeless or living in a shelter at this time	
	*Release from incarceration in past year, current charges, or current parole/probation?	
	*Most recent hospitalization and reason	
	*Psychiatric ED visits in the past year	
	Probable risk for adverse event (e.g., death, disability, inpatient or nursing home admission)	
	Lack of or inadequate social/ family/housing support	
	Lack of or inadequate connectivity with healthcare system	
	Difficulty adhering to treatments or difficulty managing medications	
	Outpatient mental health services in past year	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	
	Suicidal Ideation	
	History of Suicide Attempts	
	Homicidal Ideation	
	History of Violence	
	Legal History/Sex Offender Status	
	Care Manager visitation issues (e.g., household hazards, safety concerns)	

	Unsafe Living Environment	
	Other - Specify	

NARRATIVE

Provide any additional information that may be helpful in assignment to a Care Management Agency:

*********All referral forms must include the completed Psyckes and Health e Connections consents below signed by the client or Proof of Diagnosis. The releases must be filled out in its entirity and signed by the Enrollee or Legal Guardian/Representative.***********

For staff use only:

HH+ (Circle based on information from above) - Yes or No

HARP Status (Circle one) – No Eligible Enrolled

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | PSYCKES

Consent Form

Catholic Charities of Onondaga County

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org**, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

◯ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

◯ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

1. **How providers can use your health information.** They can use it only to:
   - Provide medical treatment, care coordination, and related services.
   - Evaluate and improve the quality of medical care.
   - Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2. **What information they can access.** If you give consent, Catholic Charities of Onondaga County can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4. **Who can access your information, with your consent.** Catholic Charities of Onondaga County 's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Catholic Charities of Onondaga County. Staff members who perform the duties listed in #1 above also can access your information.

5. **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:
   - _____ at _____, or
   - the NYS Office of Mental Health Customer Relations at **800-597-8481**.

6. **Sharing of your information.** Catholic Charities of Onondaga County may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7. **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Catholic Charities of Onondaga County, or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to _____. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling _____ at _____. Please note, providers who get your health information through Catholic Charities of Onondaga County while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9. **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

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healtheconnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.