Cayuga Centers Health Home Care Management Referral

Eligibility Category Information
(if ICD-10 code(s) are available, please include them

1. **Child/Youth must be Medicaid enrolled**
   Yes they are enrolled ☐
2. **Child/Youth resides in what county:** _____

3. **Child/Youth meets the NYS DOH eligibility criteria of ONE of the following (a - e):**
   a. ☐ Two or more Chronic Conditions;
   Chronic Conditions: _____

OR

b. ☐ HIV/AIDS: ***single qualifying condition***

OR

c. ☐ Complex Trauma: ***single qualifying condition***

OR

d. ☐ Serious Emotional Disturbance (SED): ***single qualifying condition***

Other Risk Factors (check all that apply):

☐ At risk for adverse event (e.g. death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement);
☐ Has inadequate social/family/housing support, or serious disruptions in family relationships;
☐ Has inadequate connectivity with healthcare system;
☐ Does not adhere to treatments or has difficulty managing medications;
☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
☐ Has deficits in activities of daily living, learning or cognition issues; OR
☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

Identifying Information of Child/Youth			
Child's Name:		**Date of Birth:**	
Gender:		**Medicaid #:** (ie:AB34567C)	
Phone:		**County of Residence:**	
Current Address:		**Managed Care Organization:**	
***Indicate any need for language/interpretation services; specify language spoken if other than English**			
Foster Care: Is the child currently in Foster Care?	☐ Yes ☐ No ☐ Unknown	If a child is currently in Foster Care, only the Local Department of Social Services (LDSS) may complete the referral, which must be completed by them in the Medicaid Analytics & Performance Portal (MAPP)	

Consent to Refer:

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

☐ Parent ☐ Guardian ☐ Legally Authorized Representative

OR

☐ Child/Youth who is:

○ 18 years or older ○ A parent ○ Pregnant ○ Married

Consenter Information (Please provide the following information about the person that you received consent from to make referral)			
Name:		**Relationship with child/youth:**	
Phone:		**Best time to reach:**	
Preferred Means to contact:	☐ Call ☐ Text ☐ Email		
Parent Health Home Connectivity Is the child/youth's parent or guardian currently enrolled in the Health Home Program?			☐ No ☐ Yes

Contact Information for Person Completing Referral			
Name:		**Title:**	
Organization:		**Address:**	
Phone:		**Email:**	

Child/Youth Inpatient Status:
Is the child/youth currently admitted to an inpatient facility?
☐ No ☐ Yes
If yes, Name of the Facility? Date of Discharge?

**Note: If available, please send Medical Records of the child/youth with completed form*

Narrative
Provide any additional information, safety concerns, or family's preferences that may be helpful in assignment to a care management agency:

Please fax or email completed form to:

Jennifer Muzio
Assistant Director of Care Management Services
5 Computer Drive W, Suite 200
Albany, NY 12205
Fax: 518-650-0594
jennifer.muzio@cayugacenters.org

Client Authorization for Services

The Parent or legal guardian must sign this authorization.

Your signature authorizes your minor child to participate in the **Care Coordination (Children's Health Homes)** Program.

Your signature also authorizes the Care Manager staff to work with other household members during the intervention period.

NAME OF CHILD: _____

PARENT/LEGAL GUARDIAN: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____

WITNESS SIGNATURE: _____

DATE: _____