

COMMUNITY REFERRAL FOR HEALTH HOME CARE MANAGEMENT SERVICES

Vanderheyden is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible children/youth 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.
- 2. Child/youth meets the NYS DOH eligibility criteria of: a. two chronic conditions, or b. HIV/AIDS, or c. complex trauma or, d. serious emotional disturbance or e. one developmental disability and one or more chronic conditions.
- 3. Child/youth has significant behavioral, medical or social risk factors which can be addressed through care management.
- 1. Complete the attached Community Referral Application Form, including as much detail as possible to allow Vanderheyden to verify eligibility for health home care management services.
- 2. You may return the completed Application directly to Vanderheyden Care Management Supervisor via secure e-mail, fax, or mail:

Email bpiccolo@vanderheyden.org

Fax 518-238-3882

Mail Vanderheyden Attn: Health Homes P.O. BOX 219 Wynantskill, NY 12198

Approved children/youth will be assigned to a Care Management Agency who will conduct 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: Care Manager Supervisor (518-833-4951)

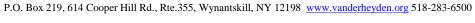
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Identifying Information

Child's Name:	Date of Birth:
Current Address:	Medicaid CIN:
Phone:	Social Security:
Indicate need for language/interpretation se	ervices; Specify language if other than English:
complete the referral, which must be comp	er Care? ☐ Yes ☐ No ☐ Unknown the Local Department of Social Services (LDSS) may eleted by them in the Medicaid Analytics &
Performance Portal (MAPP).	
in receiving Health Home Care Manageme from a Care Manager. Consent to make the parent/guardian/legally authorized represer	ntative for children up until the age of 18. For ried, a parent, or pregnant may provide consent on
☐ Parent ☐ Guardian ☐ I	Legally Authorize Representative
☐ Child/Youth who is (circle one): 18 ye	ears or older A parent Pregnant Married

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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:	Phone:
Contact Information for Dayson Completi	na Defennel
Contact Information for Person Completion	iig Keiertai:
Name:	Title:
Organization:	
Phone:	Email:
•	nild/youth currently receiving preventive services? name if known):
Child/Youth Inpatient Status:	
Is the child/youth current admitted to an inpa	tient facility?
□ No □ Yes	
If yes, what is the name of the facility?	
Expected discharge Date?	

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Eligibility Category Information (if ICD-10 code(s) are available please include them) ☐ Two or more chronic conditions (examples include: asthma, obesity, substance use disorder, diabetes, sickle cell anemia, cystic fibrosis, spina bifida, congenital heart problems, etc.). List qualifying chronic conditions: OR ☐ Serious Emotional Disturbance (SED) OR ☐ Complex Trauma OR ☐ HIV/AIDS OR ☐ One developmental disability (intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, prader-willi syndrome, or autism) and one or more chronic conditions. List qualifying developmental and chronic conditions: **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; ☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health

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Home



Narrative: Provide any additional information that may be helpful to a care management agency:

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