VANDERHEYDEN

Giving new life to youth, adults and families since 1833

•Family Focused •Trauma Informed •Community Based

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 services; Specify language 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 should be a verbal confirmation that the child or family is interested in receiving Health Home Care Management or interested in learning more about the program from a Care Manager. 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 Authorize Representative

☐ Child/Youth who is (circle one): 18 years 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 Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email:

Preventive Services Connectivity: Is the child/youth currently receiving preventive services?

☐ No ☐ Yes (please specify provider name if known): _____

Child/Youth Inpatient Status:

Is the child/youth current admitted to an inpatient facility?

☐ No ☐ Yes

If yes, what is the name of the facility? _____

Expected discharge Date? _____

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 Home

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