HHUNY Health Home Care Management - Community Referral Application

Identifying Information

Name:	Date of Birth:	Gender:
Address:	Medicaid CIN #:	
	Medicaid Managed Care Organization Name:	
	County of Residence:	
Phone:	Cell Phone:	
Indicate any need for language/interpretation services; specify language spoken if other than English:		

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 condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	BMI > 25	
	C	Other Chronic Conditions (Specify)	

Risk Factors - Check All that Apply

Check	Category	Detail Indicating How Referral Meets the Risk Factor
	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	
	Non-adherence to treatments or medication(s) or difficulty managing medications	
	Recent release from incarceration	
	Recent release from psychiatric hospitalization	
	Deficits in activities of daily living such as dressing, eating, etc.	
	Learning or cognition issues	

Narrative

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

Specify Preferred or Recommended Care Management Agency, if any:___________________________________

Contact Information for Person Completing Referral:

Name:	Title:
Organization:	
Phone:	Email:

PERMISSION TO USE AND DISCLOSE CONFIDENTIAL INFORMATION

By signing this Consent Form, you permit people involved in your care to share your health information so that your doctors and other providers can have a complete picture of your health and help you get better care. Your health records provide information about your illnesses, injuries, medicines and/or test results. Your records may include sensitive information, such as information about HIV status, mental health records, reproductive health records, drug and alcohol treatment, and genetic information.

If you permit disclosure, your health information will only be used to provide you with medical treatment and related health and social services. This includes referral from one provider to another, consultation regarding care, provision of health care services, and coordination of care among providers. Your health information may be re-disclosed only as permitted by state and federal laws and regulations. These laws limit re-disclosure of information about your treatment at a substance abuse or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information will not be the basis for denial of health services or health insurance. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the providers listed in Attachment A. But anyone who receives information while your consent is in effect may retain it. Even if you withdraw your consent, they are not required to return your information or remove it from their records.

You are entitled to get a copy of this Consent Form after you sign it.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION

1. The person whose information may be used or disclosed is:

   Name: ____.

   Date of Birth: ____.

2. The information that may be disclosed includes all records of diagnosis and health care treatment and all education records including, but not limited to: Mental health records, except that disclosure of psychotherapy notes is not permitted; Substance abuse treatment records; HIV related information; Genetic information; Information about sexually transmitted diseases; and Education records.
2. This information may be disclosed to the persons or organizations listed in Attachment A.
3. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
4. Use and disclosure of this information is permitted only as necessary for the purposes of the provision of delivery of health and social services, including outreach, service planning, referrals, care coordination, direct care, and monitoring of the quality of service.
5. This permission expires on ____________ (date).
6. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose health information as needed to complete treatment.

I am the person whose records will be used or disclosed, or that individual's personal representative. (If personal representative, please enter relationship ____________________.)

I give permission to use and disclose my records as described in this document.

____

Signature Date

CONSENT TO DISCLOSE HEALTH RECORDS – ATTACHMENT A

HHUNY CENTRAL

Health information may be disclosed for purposes of treatment to the people and organizations listed below.

- ACR Health
- Catholic Charities of Cortland County
- Catholic Charities of Oswego County
- Cayuga County Community Mental Health Center
- Coordinated Care Services, Inc.
- Elmira Psychiatric Center
- Excellus Health Plans
- Family Services of Chemung
- Hillside Family of Agencies
- Liberty Resources, Inc.
- Magellan Behavioral Health
- New York Care Coordination Program, Inc.
- New York State Catholic Health Plan dba Fidelis Care New York
- New York State Office of Mental Health
- New York State Office of Alcohol and Substance Abuse Services
- Onondaga Case Management Services
- Oswego County Opportunities, Inc.
- Oswego Health
- Rehabilitation Support Services
- Southern Tier Care Coordination
- Total Care
- Tioga County Department of Mental Health
- Tompkins County Mental Health Services
- United Healthcare
- Visiting Nurse Association Homecare of Central New York

COUNTY OF ONONDAGA
Department of Adult and Long Term Care Services

John H. Mulroy Civic Center
421 Montgomery Street, Syracuse, NY 13202
SPOA Adult (315) 435-3355 Ext. 4695
SPOA Adult FAX (315) 435-3279
www.ongov.net

Joanne M. Mahoney, County Executive

Lisa D. Alford, Commissioner
Barry L. Beck, LMSW, Deputy Commissioner

Onondaga County Department of Mental Health SPOA (Adults)
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.
2. The person whose information may be used or disclosed is:

   Name: ______________________________. **Date of Birth:** _________________

3. The information that may be used or disclosed includes (check all that applies):

   ☒ Mental health records
   ☒ Alcohol/Drug Records
   ☐ School or Education Records
   ☒ Health records
   ☒ Health Home Application
   ☐ All of the records listed above

4. This information may be disclosed by:

   ☒ Any person or organization that possesses the information to be disclosed
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations that provide services to me:

   ____ ____
   ____ ____

5. This information may be disclosed to:

   ☒ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations:

   ____ ____
   ____ ____

6. The purposes for which this information may be used and disclosed include:

   - Evaluation of eligibility to participate in a program supported by the Onondaga County Department of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and

- Health Care Operations such as quality assurance.

Onondaga County Department of Mental Health SPOA
Permission to Use and Disclose Confidential Information (con't.)

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. This permission expires (check applicable box):

☐ On ___________________________

☐ Upon the following event: ____

9. This permission is limited as follows:

☐ Permission only applies to records for the following time period: ______________________ to _______________

☐ Other limitation: ____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

____ ____________________________

Signature **Date**

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is___ ____. I give permission to use and disclose my records as described in this document.

____ ____________________________

Signature Date

____

Print Name

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Onondaga County.

Altamont
ARISE
Auburn Memorial Hospital
Catholic Charities
Central New York Services
Chadwick Residence
CNY Developmental Services Office
Community General Hospital
Conifer Park
Contact
Crouse Hospital.
Health Homes of Upstate NY
Hillside Children's Center
Huntington Family Center
Hutchings Psychiatric Center

Interfaith Works of CNY
Jewish Family Center
Kalet's Adult Residence
Legal Aid Society of CNY
Liberty Resources and the Brownell Center
Loretto Community Residences
Mental Health Association in Onondaga County
Mental Hygiene Legal Services
Newark Wayne Hospital
Onondaga Case Management Services
Onondaga County: DSS, Adult Protective Services, Dept of Aging and Youth
Onondaga County Department of Mental Health
Onondaga Nation Healing Center
Oswego Hospital

Salvation Army
Spanish Action League
St. Joseph's Hospital Health Care
Syracuse Behavioral Health
Syracuse Community Health Center
Syracuse Housing Authority
Syracuse Rescue Mission
Syracuse Veteran's Administration
Transitional Living Services
Upstate Medical University
Vera House
VESID
YWCA
YMCA

COUNTY OF ONONDAGA
Department of Mental Health
ADULT SPOA

John H. Mulroy Civic Center
421 Montgomery Street, Syracuse, NY 13202
(315) 435-3355 FAX (315) 435-3279
www.ongov.net www.ocdmh.ongov.net

Joanne M. Mahoney, County Executive

Lisa D. Alford, Commissioner
Barry L. Beck, LMSW, Deputy Commissioner

CONFIDENTIAL
AUTHORIZATION FOR RELEASE OF INFORMATION

Notice: For substance abuse information, use a cover sheet referencing Federal Law 42 CFR Part 2.
HIV: Use form DOH-2557. Do not send HIV related information with this form.

Participant Name:		**DOB:**
I authorize the following person/agency to provide and/or receive the disclosure of my health information:		
Agency		
Dates of Treatment:	**From:** **To:**	
Contact Person		
Address		
City, State, Zip		
Phone		
Fax		

(Each person/agency requires a separate consent form)

Staff Person Requesting/Releasing: **Jennifer Feliciano**	**Phone: (315) 435-3355 x 4997**

Nature or Extent of Information to be Released (please check all that apply):

- ☒ Services Desired
- ☒ Involvement in Program
- ☒ Evaluation/Assessment
- ☒ Progress, Treatment, Goals and Service Plans
- ☒ Psychosocial Evaluation
- ☒ Psychiatric Evaluation
- ☒ Medical History and Physical Examination
- ☒ Medication Record
- ☒ Financial and Demographic Information
- ☒ Psychological Testing Results
- ☐ Results of Laboratory and Diagnosis Tests
- ☒ Vocational History/Assessments
- ☒ Legal/Criminal Justice History
- ☒ Discharge Summary/Cont. Care Plan
- ☒ Recommendations
- ☒ Axis I, II, III, IV and V Diagnosis
- ☐ Verification of Health Insurance and Income
- ☐ Other:

Reason for Release of Information (check all that apply):

- ☒ To assist in assessment/service planning
- ☒ To refer for services
- ☐ Care Coordination
- ☒ SPOA Meeting & Planning
- ☒ To establish program eligibility
- ☐ To permit discharge planning
- ☐ Other (please specify):

I consent to the release of information described above. This authorization (check one):

☐ Is for a one-time release
☒ Will expire on: ☐ 90 days following signature for release ☒ 1 year following signature for services release
☐ Discharge from OCMS Inc.

I may revoke my consent at any time by verbal or written notice to these agencies. Revocation will be effective upon the date the notice is received. Revocation does not apply to information furnished before that date. Re-disclosure of record information to any other party is prohibited.

Client Signature ______________________ **Date** __________

Witness Signature ______________________ Date __________

This information has been disclosed to you from records protected by federal and New York state laws and federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.