jewish family services | wny

Phone: (716)883-1914
Fax: (716) 883-7673

JFS COMMUNITY REFERRAL FOR ADULT HEALTH HOME SERVICES

JFS is accepting referrals from the community (community organizations, individuals and/or family members) for enrollment of eligible adults into Health Home Care Coordination Services.

Adults must meet all eligibility requirements to be considered for enrollment.

Health Home Care Management Services Eligibility:

- Adult currently has active Medicaid;
  AND
- Adult resides in one of the following Counties: Erie or Niagara County
  AND

Adult must have one of the following qualifying diagnoses and proof of diagnosis must be attached to this form:

a. Two chronic conditions (examples: asthma, hypertension, diabetes)
b. HIV/AIDS
c. Serious Mental Illness (examples: bipolar disorder, schizophrenia, depressive disorders)
d. Sickle cell disease
   AND

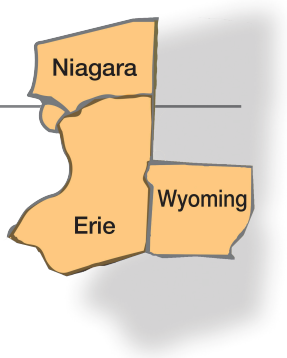
- Adult has significant behavioral, medical, or social risk factors such as, but not limited to:
  - At risk for adverse events (e.g., death, disability, inpatient or nursing home admission).
  - Has lack of or inadequate social/family/housing support or serious disruptions in family relationships.
  - Has lack of or inadequate connectivity with healthcare system.
  - Does not adhere to treatments or medication(s) or difficulty managing medications.
  - Has recently been released from incarceration, placement, detention, or psychiatric hospitalization.

How to Make a Referral to JFS for health home care coordination:

1. Complete the attached Community Referral Form, including as much detail as possible to allow JFS to verify eligibility for services. Fields highlighted yellow, at minimum, are required to process the referral.
2. Attached proof of qualifying diagnosis for the completed Community Referral Form.
3. Return the completed Community Referral Form directly to JFS:

Email:
Erie County: eriecarecoordination@jfswny.org
Niagara County: niagaracarecoordination@jfswny.org

Fax: (716) 883-7673



If the referral is for a youth between the ages of 18-21, please complete the following:
Is the youth in Foster Care? Yes No If yes, please contact your local DSS
Does the youth prefer to be served under the Adult HH system? Yes No
Does the youth prefer to be served under the Children's HH system? Yes No
If yes, please complete child/youth referral at www.childrenshealthhome.com

IDENTIFYING INFORMATION

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:	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 conditions	
	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	
	Difficulty adhering to treatments or difficulty managing medications	
	Recent release from incarceration	
	History of incarceration	
	Most recent psychiatric hospitalization discharge date	
	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	
	Unsafe Living Environment	
	Care Manager visitation issues (e.g., household hazards, safety concerns)	
	Other - Specify	

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: Jewish Family Services of Western New York	
Contact Information for Person Completing Referral:	Title:
Organization:	
Phone:	Email:*

***The eligibility determination and agency assignment is communicated to both the referral source and the agency receiving the assignment via secure email.**

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.
3. This information may be disclosed to the persons or organizations listed in Attachment A.
4. This information may be disclosed by any person or organization that holds a record described below, including those listed in Attachment A.
5. 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.
6. This permission expires on:

Date: N/A

7. 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: