Children's Health Home Program

1. Child/youth currently has active Medicaid;
   AND
2. Child/youth resides in Monroe County;
   AND
3. Child/youth meets NY State DOH eligibility criteria of:
   a) Two chronic conditions, or
   b) HIV/AIDS, or
   c) Complex Trauma, or
   d) Serious Emotional Disturbance
   e) HCBS eligible, or
   f) Sickle Cell
   AND
4. Child/youth has significant behavioral, medical, developmental, or social risk factors which can be addressed through care management.

How to make a Referral to Golisano Children's Health Home Program

Complete the attached community referral applications form. Please include

Foster Care: *Please note that non-*
Referral Portal in MAPP after consultation with LDSS.

Consent to Refer:

Parent Health Home Connectivity:

Is the child/youth's parent or guardian currently enrolled in the Health Home Program?

No Yes

Note: if the child/youth's parent or guardian is not currently enrolled in the Health Home program, if you or they believe that the parent/guardian is eligible and the parent/guardian is interested, you can complete a referral for Adult Health Home Services. If the parent or guardian lives in Western, Finger Lakes, or the Central regions, Health Homes of Upstate New York (HHUNY) may be able to serve him or her. Navigate to www.hhuny.org to complete the adult Health Home referral. If outside of these regions, you can refer to other adult Health Homes by reaching out to Health

Contact Information for Person Completing Referral:

Preventative Services Connectivity:

Child/Youth Inpatient Status:

Risk Factors- Check All that Apply and Provide Explanation of how Child/Youth Exhibits Risk Factors

Adverse Events Risk:

☐ Member currently involved with mandated preventative services. Must specify date issued services and provider of service: *Required Explanation*:

Member had recent inpatient/ED/psychiatric hospital/Detox within the last 6 months. Must specify name of institution and date of release. *Required Explanation*:

☐ Member recently out of home placement (foster care, relative, RTF, RTC, etc.) within the last 6 months. Must specify name of institution and date of release. *Required Explanation:*

☐ Member recently diagnosed with a terminal illness/condition within the last 6 months. Must specify condition and the date diagnosed. *Required Explanation*:

☐ Member received an initial Disability Determination (SSI or DOH Disability Certificate/letter) within the last 6 months. *Required Explanation:*

☐ Released from jail, prison/juvenile detention, involved with probation, PINS, family court within the last 6 months. Must specify name of program and date of release/court/probation. *Required Explanation:*

Healthcare Risk:

☐ During last 3 months, the member has been unable to schedule and keep healthcare appointments (medical, psychiatric, etc.) and they do not know who their provider(s) is and how to contact their provider(s).

☐ Member does not have at least one of the following: Primary Care Provider, mental health provider, substance use provider,