NEW YORK STATE OF OPPORTUNITY. Office of Temporary and Disability Assistance | NEW YORK STATE Department of Health

Health Home Referral Consent Form

This form is asking for your agreement to participate in a screening questionnaire to determine if you may qualify for Medicaid-funded New York State Department of Health (DOH) Health Home services that provide intensive care management services to Medicaid eligible individuals who have chronic conditions.

If you agree to participate, you will be asked to complete the *Health Home Eligibility Screening and Referral Form*, which includes providing your Medicaid Client Identification Number (CIN). You will also need to identify your protected health information which could include any chronic conditions you may have, including HIV/AIDS, a Serious Mental Illness (SMI), substance use disorders or other chronic medical conditions.

I understand I am authorizing the district to disclose the personal and medical information obtained from this screening to a health home provider as designated by the State of New York to determine if I am eligible for Health Home services.

What you Should Know:

- Participation in this screening is voluntary. You can decide not to participate. You may choose to stop the screening at any point before you finish.
- Any services or benefits you are currently receiving **will not** be affected if you choose not to participate in the screening.
- Completing this screening tool will not tell you if you are eligible for Health Homes services, but will refer you to a Health Home services coordinator who will determine eligibility and enroll you as a Health Home services member if you are eligible.
- Under federal and New York State laws and regulations, your health information is private and cannot be released to other people without your permission. The Health Home cannot release your information unless you consent or the law provides for it, regardless of whether your health information is stored on a computer system or on paper. Additional laws and regulations concern the release of HIV/AIDS, mental health, and drug and alcohol use information. The district obtaining this information for this screening and the Health Home must strictly adhere to these laws and regulations.

Agreement to participate:

I have read or have had explained to me, the information above regarding participation in the Health Home screening, and voluntarily consent to participate in the Health Home eligibility screening. I understand that I may withdraw my consent at any time before I complete the screening.

I give permission to the social services districts and New York State to share information obtained from this screening with a health home provider as designated by the State of New York to assess whether I can receive additional benefits for which I may be eligible. I understand participation in this screening and if eligible, enrollment into a health home, is voluntary and I may opt out at any time.

Name: _____

Signature: _____ **Date:** _____