Section 8 – How Providers Can Refer Members to Senior Health Partners

8.1 Senior Health Partners /Provider Partnership

Senior Health Partners views and works with each vendor as a partner in care. Senior Health Partners staff works with providers to facilitate the right services are provided in the right place for the right amount of time based on a member's needs. Selected providers also participate in quality improvement and other initiatives designed to maximize member outcomes and satisfaction. When providers identify clients they feel will both qualify for and benefit from the unique services Senior Health Partners provides, we ask that you contact us. The following section details the instructions and form to be used for making a referral to Senior Health Partners.

8.2 Instructions for Providers to Make Referrals

A Referral to Senior Health Partners is a Phone Call Away

⇨ Call Intake Team at **(212) 360-0067** or **(866) 585-9280**

⇨ Fax Senior Health Partners' Referral Form to: **(212) 360-1121**

Upon Referral the Intake Assessment Begins

Relationship Coordinator

- Contacts client within 24-48 hours to schedule a home visit
- Schedules home visits appointments for the Enrollment and Intake Nurses

Enrollment Specialist

- Conducts home visit, with significant other present
- Explains covered & coordinated services, answers all questions
- Obtains client authorization for an Intake Nurse Assessment
- Refers client in need of new Medicaid to the Entitlement Specialist Team

An Entitlement /Medicaid Specialist

- Completes /submits new Medicaid application for client
- Completes recertification application, as needed

Intake Nurses

- Conduct a functional, performance, environmental and cognitive assessment
- Prepare an initial plan of care with client/family input.
- Communicate /confirm with Primary Care Provider (medications, diagnosis and recommended plan of care) as needed
- Obtains client voluntary signed Enrollment Agreement

Marketing:

- Communicate the outcome to Referring Source

Healthfirst CompleteCare (HMO SNP) & Managed Long-Term Care (MLTC) Referral Form

Please fill in all requested information below and fax your referral to: <(212) 360-1121>. You may contact us or to receive more information at <(212) 360-0067, Monday to Friday, 9:00 AM – 5:00 PM>.

REFERRAL SOURCE INFORMATION

Date: _____ Name: _____ Referring Agency/Organization: _____

Tel: _____ Fax: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

CLIENT INFORMATION **REFERRAL FOR :** ❒ MAP ❒ MLTC

Name: _____ ____ _____
Last *Initial* *First*

Address_____ _____ _____ _____ _____
Street Number Apt. # City State Zip Code

Tel: _____ *Date of Birth _____ * **Must be 21 for MLTC only**

Primary Care Provider _____
Primary Language: ❒ English ❒ Spanish ❒ Other: _____ Female ❒ Male ❒

Emergency Contact Name: _____, _____ _____
Last *First* *Relationship*

Tel: _____ (H) _____(W)_____(C)_____

*Medicaid No. _____ Medicare No. _____

* If no Medicaid, does client want to apply? ❒ Yes ❒ No Do you have ESRD? ❒ Yes ❒ No

Current Services in the Home? ❒ Yes ❒ No If yes, provide the name of the vendor: _____

Diagnosis: ❒ Dementia ❒ Diabetes ❒ Hypertension ❒ High Cholesterol ❒ Osteoarthritis

Other comments:

_____

REFERRAL SOURCE ATTESTATION

I_____attest that the client was informed of the referral and agrees to receive more information about the MAP and/or MLTC program.

_____ _____
Signature **Date**

TO ALL LICENSED HOME CARE AGENCIES:

If this client is presently receiving services from a Certified Home Health Care Agency (CHHA), the Licensed Home Care Agency attests that the CHHA has been notified that this client is being referred to Healthfirst CompleteCare (HMO SNP) or Senior Health Partners (SHP) regarding potential enrollment.

_____ _____
Signature **Date**

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All information will be kept confidential. Thank you for your Referral!

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