PERSON
CENTERED
SERVICES

Learn more about our

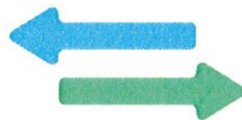
COMMUNITY RESOURCE TOOL

Are you searching for local services and supports for people with intellectual and developmental disabilities.

The Community Resource Tool houses over 3,000 resources including employment support, recreational activities, health services and medical care, day programming, housing assistance, community opportunities and many more!

Scan the codes below to be redirected to learn more!

JOIN THE NETWORK



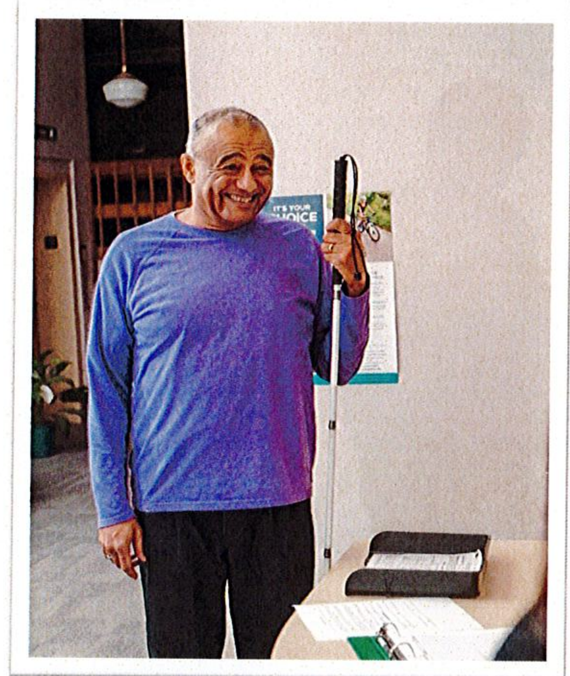
ACCESS THE TOOL

PERSON CENTERED SERVICES
Reach Your Potential

Take Control of Your Health with Linkage Coordination!

Learn how you can improve your health with the help of Linkage Coordination

As you know, Care Coordination/Health Home Organization (CCO/HH) care management services cannot formally begin until the eligibility determination process with OPWDD is completed. This process can take up to several months. Enrollment in this free, 90-day, Linkage Coordination program can help bridge the gap while you wait - by jump-starting the care management evaluation and planning processes. What can a Linkage Coordinator assist with?



- Help you understand your health and connect you to preventive healthcare services.
- Help you find your way around the healthcare system.
- Help you get an appointment with your doctor(s).
- Help you create your health and wellness goals.
- Connect you with social services you may need such as transportation, food and more.

Am I eligible for this program?

- If you are over the age of 18 and have a disability, you may qualify for this program.
- Enrollment in a Care Coordination Organization (CCO) is **not** mandatory.
- Scan the QR code to complete a five-question survey to determine your eligibility.
- If eligible, you will be contacted by a linkage coordinator to discuss next steps.

Scan QR Code to complete application now!

Your personal information will never be shared. Person Centered Services will compile and share information with the State and the CDC that will assist them in planning for and enhancing future services and supports.

SPACE IS LIMITED! DON'T MISS OUT!

Don't have a smart phone? No problem! Complete the attached form and mail to:

Person Centered Services Clinical Department
560 Delaware Avenue, Suite 400
Buffalo, NY 14202

Or email tbellaire@personcenteredservices.com

PERSON
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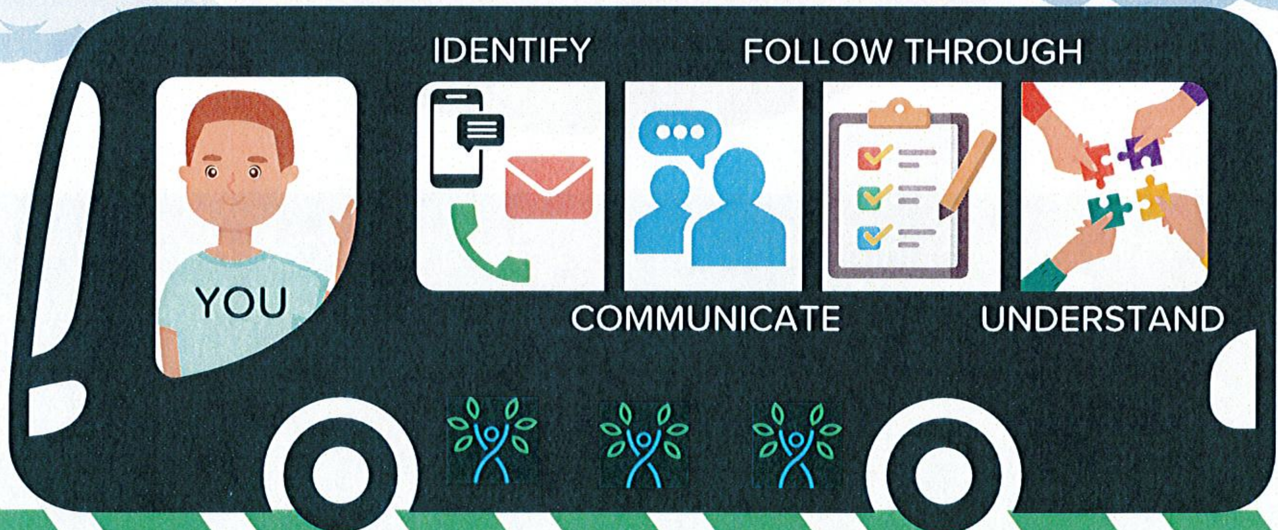
TIPS & TRICKS

HOW TO MAXIMIZE YOUR RELATIONSHIP WITH YOUR CARE COORDINATOR

CARE COORDINATOR ROLE

YOUR ROLE *- you drive the bus*



WE'RE ALL PIECES OF THE SAME PUZZLE

Who else?

Natural Support

Social Supports

Care Coordinator

Program Providers

Clinical Support

For General Information or to locate a Care Coordinator, contact (888) 977-7030 or customerservice@personcenteredservices.com between 8AM and 4:30PM.

If you're already enrolled and have an urgent need between 4:30PM and 8AM, contact our On-Call Service at (833) 200-0678.

What can a Care Coordinator do for you?

Person Centered Services' Care Coordinators work to understand your unique goals, then connect you to the supports and services that meet your needs. Backed by a large network of expert providers, Care Coordinators help individuals navigate a complex system to help you reach your full potential. Some examples of what Care Coordinators can do for you:

SUPPORTS & SERVICES

Residential, Community, and Day Habilitiation Programs:
- Help you identify and enroll in programs that fit your specific needs

Respite:
- Identify and connect you to available respite options

Employment, Education and Job Readiness:
- Assist in application to programs that meet your employment and educational goals
- Connect you to career planning, prevocational and supported employment programs

Housing Services:
- Connect you to safe, secure, appropriate and affordable housing that matches your needs
- Make your home more accessible through environmental modifications

Support Services:
- Find you a support broker to help you with self-direction
- Link you to community resources that proivde financial assistance such as a fiscal intermediary

Family Education and Support:
- Find training for families to help them in the decision-making process when it comes to managing a loved one's services
- Support families in learning about and understanding I/DD

MEDICAL, HEALTH & WELLNESS

- Link or refer you to doctors, dentists and specialists for all of your unique needs
- Advocate on your behalf to get you the best care
- Assist with suitable transportation to get you to and from appointments
- Provide assistance with understanding or remembering confusing medical information
- Schedule appointments, tests, or lab vists
- Refer you to inpatient or outpatient mental health programs
- Follow up and ensure you always have proper care and safety

Call us toll free: 1-888-977-7030

Health Home Care Coordination Basics for Providers

How did we get here?

Beginning July 1, 2018: transition from traditional Medicaid Service Coordination to Health Home Care Coordination.

This transition was part of the Medicaid Redesign Plan by New York State with the aim of preparing the Office for People With Developmental Disabilities (OPWDD) service delivery system for the overall transition to Managed Care and ensuring conflict free care management.

What is a health home?

A 'Health Home' is not a geographic or physical place. It is a group of health care and service providers (interdisciplinary team) working together to ensure people get the care and services they need to stay healthy.

When enrolled in a health home, people are linked with a Care Coordinator to assist with developing a life plan and engaging with the interdisciplinary team (IDT).

Health homes are about the whole person and supporting or linking people to the services and supports to assist with all areas of their life - not just OPWDD provider services and not just health care services.

What do Care Coordinators do?

Coordinate all intellectual and developmental disability (I/DD) services, other health-related supports, AND services or supports related to the social determinants of health (i.e., housing stability, adult learning, social opportunities).

The following is the list of the core services described in the Health Home/Care Coordination Provider Guidance Manual (regulatory document for Care Coordination Organizations) that Care Coordinators are responsible for delivering:

- **Comprehensive Care Management** – utilizing the person-centered planning process, facilitating the comprehensive assessment process, developing and implementing the life plan.
- **Care Coordination and Health Promotion** – assisting with linkage to preventative health supports, evaluating effectiveness of treatment plans and services, coordinating/gathering all health-related information.
- **Comprehensive Transitional Care** – facilitating discharge plans, ensuring follow-up after emergency department or hospital utilization, supporting people during phase of life transitions, changes in residence, etc.
- **Individual and Family Support** – facilitating advocacy or rights promotion in all areas of the person's life, ensuring services and supports are being delivered in the most culturally appropriate manner, assisting family or surrogate decision makers to be a meaningful member of the person's IDT.
- **Referral to Community and Social Support Services** – linking people to community-based providers, engaging with non-OPWDD providers to help meet the overall social needs a person may have.
- **Use of Health information Technology to Link Services** – Utilizing electronic medical records and information technology systems to link services, and to facilitate communication among team members and between the person served, their family and/or representatives, care coordination and providers.