Local Government Unit (LGU)/Single Point of Access (SPOA) and Care Management Agency (CMA) Working Relationship Form

Per the Department of Health (DOH)/Office of Mental Health (OMH) requirements to serve the Health Home Plus (HH+) for Serious Mental Illness (SMI) populations, Health Homes must verify CMAs either have an existing working relationship (or are in process of developing one within (3) months) for HH+ Care Coordination with the LGU/SPOA in their service county. This form can be used by LGUs/SPOAs to document that a CMA has a working relationship with the LGU/SPOA in their service area. If establishing a new relationship, contact with the LGU/SPOA should be made prior to completing this form.

Local Government Unit (LGU/SPOA):

County: ____________________________________________________________

Lead Contact Name: ________________________________________________

Lead Contact Telephone Number: _____________________________________

Lead Contact Email: ______________________________________________

Care Management Agency (CMA)

CMA Name: _________________________________________________________

Lead Contact Name: ________________________________________________

Lead Contact Telephone Number: _____________________________________

Lead Contact Email: ______________________________________________

Lead Health Home (HH)

HH Name: __________________________________________________________

Lead Contact Name: ________________________________________________

Lead Contact Telephone Number: _____________________________________

Lead Contact Email: ______________________________________________
Per DOH/OMH Guidance, a “working relationship” with LGU/SPOA includes:

LGU/SPOA Please check all that apply below:

1. Demonstrated ability and willingness to accept high-need SMI referrals directly from the LGU/SPOA
   CMA meets this criteria:     YES  NO

2. Participation in any county SPOA process or committee as applicable
   CMA meets this criteria:     YES  NO

3. Knowledge of LGU/SPOA protocols and resources for accessing local mental health services
   CMA meets this criteria:     YES  NO

4. Clearly defined communication process between the CMA, SPOA, and HH
   CMA meets this criteria:     YES  NO

5. Please list additional CMA contacts if needed:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

6. Please list additional of Health Home contacts if needed
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Local Government Unit Representative

____________________________________  ____________________________________________  ____________________________
Name                                           Title                                           County

____________________________________________
Date