Health Home Care Management Community Referral

Phone: 1-866-708-2912
Email: HealthHome@ahihealth.org (send encrypted only!)
Fax: 518-615-1220

IF FAXING, PLEASE CALL TO CONFIRM RECEIPT - DO NOT RELY ON 'OK' FROM FAX MACHINE

Last Name		**First Name**			
Medicaid Client ID#		**DOB**		**Sex**	
Address	______________________________ Street Apt. ______________________________ Town State Zip				
Alt. Address	______________________________ Street Apt. ______________________________ Town State Zip				
AKA (also known as)					
Home Phone		**Mobile Phone**		**Alt. Phone**	
E-mail address					

Referral Source

☐ Self, family, or friend
☐ Behavioral Health Provider
☐ Substance Abuse Treatment Program
☐ Primary Care Provider
☐ General Hospital ER
☐ General Hospital
☐ Other medical provider
☐ Corrections
☐ Other Health Home: (specify)
____

REFERRAL INFORMATION

Name		**Title**	
Agency		**Phone**	

Initial Eligibility CRITERIA (check all that apply)

☐ **Two** chronic conditions (specify):
- ☐ Mental Health Condition (Including Serious Mental Illness [adults] or Serious Emotional Disturbance.)
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25 [adults], at or above 85th percentile [children]
- ☐ Other: Specify ______________________, Specify ______________________

OR ☐ HIV/AIDS

OR ☐ Serious Mental Illness [adults] OR Serious Emotional Disturbance [children]

OR ☐ Trauma [children]

APPENDIX A

HEALTH HOME REFERRAL RATIONALE

The Health Home program is designed for Medicaid-eligible people with significant behavioral, medical, or social risk factors which can be addressed through care management. **Please briefly indicate why you believe this individual is appropriate for the Health Home program:**

Adirondack Health Institute Health Home - Patient Consent

I agree that ____, the "Referring Agency or Individual" may disclose my/my child's name, address, telephone number, email address, and Health Home eligibility criteria to Adirondack Health Institute Health Home (AHIHH) to (i) determine if I am eligible to receive care management services from AHIHH and (ii) contact me about these services if I am eligible.

I understand that the information disclosed to AHIHH may include (i) information related to HIV/AIDS, (ii) records of any treatment I/my child may have received from licensed mental health facilities or programs and (iii) records of any treatment I/my child received from federally assisted alcohol or drug abuse treatment facilities or programs.

This consent will be valid for one year from the date I sign this form.

I understand that:

(1) I may withdraw this consent in writing at any time, except to the extent Referring Agency and/or AHIHH has already taken action in reliance on this consent.

(2) This consent is voluntary and Referring Agency may not condition treatment on my willingness to sign this consent.

(3) I have a right to a signed copy of this consent.

(4) Any information disclosed under this consent may be re-disclosed by AHIHH only as permitted by applicable state and federal law.

I have read and fully understand this consent form. By signing below, I authorize Referring Agency to disclose information about me/my child consistent with the terms of this consent.

Name of Patient: ______________________________

By: ____ Date: ________________
Signature of Individual or Parent/Guardian

Basis of Personal Representative's Authority (if applicable): _____________________________

If you prefer a specific agency within the AHI Health Home to provide your Care Management services, please indicate below:

☐ Alliance for Positive Health
☐ Behavioral Health Services North
☐ Children's Health Network
☐ Citizen Advocates
☐ Essex County Mental Health Services
☐ Glens Falls Hospital
☐ HCR Care Management
☐ Mental Health Association in Essex County
☐ Transitional Services Association
☐ University of Vermont Health Network/CVPH
☐ Berkshire Farm Center
☐ Children's Home of Jefferson County
☐ Community Maternity Services
☐ Families First in Essex
☐ Hamilton County Community Services
☐ Hudson Headwaters Health Network
☐ St. Anne Institute
☐ United Helpers Mosaic
☐ Warren-Washington Association for Mental Health

Please note we cannot guarantee your choice depending on capacity, geography, and specialty area.