Health Home Care Management Community Referral

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

☐ **Adult Health Home Referral** ☐ **Children's Health Home Referral**

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

Last Name			First Name		
Preferred Name:					
Medicaid CIN (REQUIRED):		DOB		Gender	
Consenter Name (referral to Children's Health Home)					
Address	Street _______________ Apt. Town _______________ State Zip				
Home Phone		**Mobile Phone**		**Alt. Phone**	
E-mail address					

If this is a referral to children's Health Home, please answer:			
Is the child's parent or guardian currently enrolled in Health Home?	☐Yes ☐No	**Is the child currently in foster care?**	☐Yes ☐No

Referral Source			
Name		**Title**	
Agency		**Phone #**	
Address	Street _______________ Apt. Town _______________ State Zip		
Email Address			

Initial Eligibility Criteria (check all that apply)

☐ **Two** chronic conditions (specify):

- ☐ Mental Health Condition (Including Serious Emotional Disturbance)
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI at or above 85th percentile (for children) OR Over 25 (for Adults)
- ☐ Other: Specify_______________, Specify _______________

OR ☐ HIV/AIDS

OR ☐ Serious Mental Illness OR Serious Emotional Disturbance

OR ☐ Complex Trauma (Children's Health Home only)

Member Information:	
Current Living Situation:	☐ Currently Homeless ☐ Currently housed ☐ At Risk of Homelessness ☐ unknown
Primary Diagnosis and/or ICD 10 Code (*if known*):	
Has the member ever experienced an incarceration?	☐ Yes ☐ No ☐ Unknown
Has the member experienced a recent hospitalization or ER visit?	☐ Yes ☐ No ☐ Unknown Date of Discharge:
Has the member experienced a recent inpatient stay for substance abuse treatment?	☐ Yes ☐ No ☐ Unknown Date of Discharge:
Is the member currently inpatient at a Hospital or Facility?	☐ Yes ☐ No ☐ Unknown
If yes:	Facility name:
	Anticipated Date of Discharge:
	Any additional information regarding their current setting:

Reason for the Referral

Safety Concerns		
☐ History of aggressive behavior with providers	☐ Access to firearms	☐ Infestation (bedbugs, etc.)
☐ Registered Sex Offender	☐ None	☐ Other:

Appropriateness Criteria (check all that apply)

- ☐ Unstable housing
- ☐ Lack of social/family supports/ disruption in family relationships
- ☐ Deficits in activities of daily living
- ☐ Non-adherence to treatments
- ☐ Inadequate connectivity with healthcare system and/or other systems of care
- ☐ Learning or cognitive issues
- ☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- ☐ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)

Adirondack Health Institute Health Home – Patient Consent

I agree that ______________________________________, the "Referring Agency of 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.
5. 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:

☐ AHI's Community Access Team (Adults/Children)
☐ Behavioral Health Service North (Adults/Children)
☐ Champlain Valley Family Center (Adults)
☐ Community Connections of Franklin County (Adults)
☐ Fort Hudson Care Management (Adults)
☐ Families First in Essex County (Children)
☐ Hamilton County Community Services (Adults)
☐ Hudson Headwaters Health Network (Adults/Children)
☐ The Salvation Army (Adults/Children)
☐ United Helpers Mosaic (Adults/Children)
☐ Warren-Washington Association for Mental Health (Adults/Children)
☐ Alliance for Positive Health (Adults)
☐ Catholic Charities Care Coordination Services (Adults)
☐ Citizen Advocates (Adults/Children)
☐ Essex County Mental Health Services (Adults)
☐ Glens Falls Hospital (Adults/Children)
☐ HCR Care Management (Adults/Children)
☐ Mental Health Association of Essex County (Adults)
☐ RISE Health Housing and Support Services – TSA (Adults/Children)
☐ St. Lawrence Psychiatric Center (Adults)
☐ University of Vermont Health Network/CVPH (Adults)

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