Children's 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

Child's Last Name			Child's First Name		
Medicaid Client ID (CIN)#		DOB		Gender	
Consenter Name			**Relationship to Child**		
Consenter's Address	Street _____ Apt. _____ Town _____ State _____ Zip _____				
Home Phone		**Mobile Phone**		**Alt. Phone**	
E-mail address					
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
- ☐ Other: Specify _____, Specify _____

OR ☐ HIV/AIDS

OR ☐ Serious Emotional Disturbance

OR ☐ Trauma

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 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:

☐ Behavioral Health Services North
☐ Citizen Advocates
☐ Families First in Essex
☐ Glens Falls Hospital
☐ Hudson Headwaters Health Network
☐ United Helpers Mosaic
☐ Warren-Washington Association for Mental Health

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