AHI Health Home Care Management Inter-Agency Transfer Form

Phone: 1-866-708-2912
Fax: 518-615-1220

IF FAXING, PLEASE CALL TO CONFIRM RECEIPT

Last Name		**First Name**	
Medicaid Client ID# (CIN #)		**Requested Start Date with New Agency**	

Verify that the items below are current in the AHIHH Care Management Record System	**Notes/Comments:**
Mailing address	
Physical address (if different)	
Phone number	
Secondary phone number (if applicable)	
E-mail address (if applicable)	

KEY AREAS OF FOCUS UPON TRANSFER (I.e. housing, PCP connectivity, mental health service establishment, etc.)

REFERRAL INFORMATION

Care Manager Name		**E-mail**	
Agency		**Phone**	
Member Status	☐ Outreach ☐Enrolled	**Current Agency will bill through:**	

ELIGIBILITY CRITERIA [if known] (check all that apply)

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

- ☐ Mental Health Condition
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Heart Disease
- ☐ BMI over 25
- ☐ Diabetes
- ☐ Other: Specify ____

OR ☐ HIV/AIDS

OR ☐ Serious and persistent mental illness

☐ **Diagnostic information from a licensed provider uploaded to AHI's Record System** (for enrolled individuals only)

CONSENT- to be completed for enrolled individuals only- only one of the three boxes should be checked

☐ **New agency listed on existing DOH-5055 Consent**

☐ **Client declined to include new agency listed on existing DOH-5055 Consent or consent not in place** *In these cases, AHI will reach out to the individual to inquire about willingness to continue care management.*

To be completed only if AHI Care Management Agencies are not listed on DOH-5055 Consent:

☐ I agree that ________________________________, the "Referring Agency or Individual" may disclose my care plan, assessments, contact information, and diagnostic information to Adirondack Health Institute Health Home (AHIHH) so I may receive care management from another agency affiliated with the AHI Health Home. This information will be shared with the agency that will be working with me in the future. My consent will be valid for one year from the date I sign this form.

By: ____ Date: ________________

Signature of Individual or Personal Representative: ____________________________________