Adult 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 (CIN)#		**DOB**		**Gender**	
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

Name		**Title**	
Agency		**Phone**	
Email Address			

Initial Eligibility CRITERIA (check all that apply)

☐ **Two** chronic conditions (specify):
- ☐ Mental Health Condition (Including Serious Mental Illness)
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25
- ☐ Other: Specify_____, Specify _____

OR ☐ HIV/AIDS

OR ☐ Serious Mental Illness

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 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 may have received from licensed mental health facilities or programs and (iii) records of any treatment I 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 consistent with the terms of this consent.

Name of Patient: _____

By:_____Date:_____
Signature of Individual

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
☐ Behavioral Health Services North
☐ Champlain Valley Family Center
☐ Community Connections of Franklin County
☐ Fort Hudson Care Management
☐ Hamilton County Community Services
☐ Hudson Headwaters Health Network
☐ St. Lawrence Psychiatric Center
☐ Transitional Services Association
☐ University of Vermont Health Network/CVPH
☐ Alliance for Positive Health
☐ Catholic Charities Care Coordination Services
☐ Citizen Advocates
☐ Essex County Mental Health Services
☐ Glens Falls Hospital
☐ HCR Care Management
☐ Mental Health Association in Essex County
☐ The Salvation Army
☐ United Helpers Mosaic
☐ Warren-Washington Association for Mental Health

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