Care Management Agency Bottom-Up Referral Form

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

This form is for Care Management Agency use only*

Check Status that that most closely indicated the candidates/members current scenario:

☐ Urgent Referral, Referral Coordinator please enter immediately
☐ New Non-Health Home Enrollment
☐ Non-Health Home Member, now eligible for Health Home
☐ Health Home Member no longer eligible for Medicaid

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

Last Name		**First Name**			
Medicaid Client ID# (If Known)		**DOB**		**Sex**	☐ Male ☐ Female
Address	_____ Street Apt. _____ Town State Zip				
Home Phone		**Mobile Phone**		**Alt. Phone**	
E-mail address					

Originating 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) _____

CMA REFERRAL INFORMATION

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

Check Box If a Non-Health Home Program Needs to be added to Netsmart CareManager ☐

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:

☐ AHI Community Access
☐ Behavioral Health Services North
☐ Children's Home of Jefferson County
☐ Citizen Advocates
☐ Essex County Mental Health Services
☐ Fort Hudson Care Management
☐ Hamilton County Community Services
☐ Hudson Headwaters Health Network
☐ St. Anne Institute
☐ The Salvation Army
☐ United Helpers Mosaic
☐ Alliance for Positive Health
☐ Children's Health Network
☐ Champlain Valley Family Center
☐ Community Connections of Franklin County
☐ Families First in Essex
☐ Glens Falls Hospital
☐ HCR Care Management
☐ Mental Health Association in Essex County
☐ St. Lawrence Psychiatric Center
☐ Transitional Services Association
☐ University of Vermont Health Network/CVPH
☐ Warren-Washington Association for Mental Health

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