



# Children's Health Home Care Management Community Referral

Phone: 1-866-708-2912

Email: [HealthHome@ahihealth.org](mailto: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**

<b>Child's Last Name</b>		<b>Child's First Name</b>	
<b>Medicaid Client ID (CIN)#</b>	<b>DOB</b>	<b>Gender</b>	
<b>Consenter Name</b>		<b>Relationship to Child</b>	
<b>Consenter's Address</b>	Street _____ Apt. _____		
	Town _____	State _____	Zip _____
<b>Home Phone</b>	<b>Mobile Phone</b>	<b>Alt. Phone</b>	
<b>E-mail address</b>			
<b>Is the child's parent or guardian currently enrolled in Health Home?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the child currently in foster care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Referral Source</b>			
<b>Name</b>		<b>Title</b>	
<b>Agency</b>		<b>Phone #</b>	
<b>Address</b>	Street _____ Apt. _____		
	Town _____	State _____	Zip _____
<b>Email Address</b>			
<b>Initial Eligibility CRITERIA (check all that apply)</b>			
<input type="checkbox"/> <b>Two</b> chronic conditions (specify): <ul style="list-style-type: none"> <li><input type="checkbox"/> Mental Health Condition (Including Serious Emotional Disturbance)</li> <li><input type="checkbox"/> Substance Use Disorder</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Heart Disease</li> <li><input type="checkbox"/> BMI at or above 85<sup>th</sup> percentile</li> <li><input type="checkbox"/> Other: Specify _____, Specify _____</li> </ul>			
OR <input type="checkbox"/> HIV/AIDS			
OR <input type="checkbox"/> Serious Emotional Disturbance			
OR <input type="checkbox"/> Trauma			
<b>Appropriateness CRITERIA (check all that apply)</b>			
<input type="checkbox"/> Unstable housing <input type="checkbox"/> Lack of social/family supports/ disruption in family relationships <input type="checkbox"/> Deficits in activities of daily living <input type="checkbox"/> Non-adherence to treatments <input type="checkbox"/> Inadequate connectivity with healthcare system and/or other systems of care <input type="checkbox"/> Learning or cognitive issues <input type="checkbox"/> Has recently been released from incarceration, placement, detention, or psychiatric hospitalization <input type="checkbox"/> 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:**

- |  |   |
|--|---|
| <input type="checkbox"/> AHI's Community Access Team                     | <input type="checkbox"/> Behavioral Health Services North |
| <input type="checkbox"/> Citizen Advocates                               | <input type="checkbox"/> Families First in Essex County   |
| <input type="checkbox"/> Glens Falls Hospital                            | <input type="checkbox"/> Hudson Headwaters Health Network |
| <input type="checkbox"/> The Salvation Army                              | <input type="checkbox"/> United Helpers Mosaic            |
| <input type="checkbox"/> Warren-Washington Association for Mental Health |   |

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