



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 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	<hr/> Street Apt. <hr/> Town State Zip				
Home Phone		Mobile Phone		Alt. Phone	
E-mail address					
Originating Referral Source					
<input type="checkbox"/> Self, family, or friend <input type="checkbox"/> Behavioral Health Provider <input type="checkbox"/> Substance Abuse Treatment Program		<input type="checkbox"/> Primary Care Provider <input type="checkbox"/> General Hospital ER <input type="checkbox"/> General Hospital <input type="checkbox"/> Other medical provider		<input type="checkbox"/> Corrections <input type="checkbox"/> Other Health Home: (specify) <hr/>	
CMA REFERRAL INFORMATION					
Name			Title		
Agency			Phone		
Check Box If a Non-Health Home Program Needs to be added to Netsmart CareManager <input type="checkbox"/>					



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

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