Health Home Care Management Community Referral

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

☐ **Adult Health Home Referral** ☐ **Children's Health Home Referral**

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

Last Name			**First Name**		
Preferred Name:					
Medicaid CIN (REQUIRED):		**DOB**		**Gender**	
Consenter Name (referral to Children's Health Home)					
Address	Street ______ Apt. Town ______ State ______ Zip				
Home Phone		**Mobile Phone**		**Alt. Phone**	
E-mail address					
If this is a referral to children's Health Home, please answer:					
Is the child's parent or guardian currently enrolled in Health Home?	☐Yes ☐No	**Is the child currently in foster care?**		☐Yes ☐No	

Referral Source			
Name		**Title**	
Agency		**Phone #**	
Address	Street ______ Apt. Town ______ State ______ Zip		
Email Address			

Initial Eligibility Criteria (check all that apply)

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

- ☐ Mental Health Condition (Including Serious Emotional Disturbance)
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI at or above 85th percentile (for children) OR Over 25 (for Adults)
- ☐ Other: Specify________________________________, Specify ________________________________

OR ☐ HIV/AIDS

OR ☐ Serious Mental Illness OR Serious Emotional Disturbance

OR ☐ Complex Trauma (Children's Health Home only)

Member Information:	
Current Living Situation:	☐ Currently Homeless ☐ Currently housed ☐ At Risk of Homelessness ☐ unknown
Primary Diagnosis and/or ICD 10 Code (*if known*):	
Has the member ever experienced an incarceration?	☐ Yes ☐ No ☐ Unknown
Has the member experienced a recent hospitalization or ER visit?	☐ Yes ☐ No ☐ Unknown Date of Discharge:
Has the member experienced a recent inpatient stay for substance abuse treatment?	☐ Yes ☐ No ☐ Unknown Date of Discharge:
Is the member currently inpatient at a Hospital or Facility?	☐ Yes ☐ No ☐ Unknown
If yes:	Facility name:
	Anticipated Date of Discharge:
	Any additional information regarding their current setting:

Reason for the Referral

Safety Concerns		
☐ History of aggressive behavior with providers	☐ Access to firearms	☐ Infestation (bedbugs, etc.)
☐ Registered Sex Offender	☐ None	☐ Other:

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 of 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.
5. 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's Community Access Team (Adults/Children)
Behavioral Health Service North (Adults/Children)
Champlain Valley Family Center (Adults)
Community Connections of Franklin County (Adults)
Fort Hudson Care Management (Adults)
Families First in Essex County (Children)
Hamilton County Community Services (Adults)
Lakeside House (Adults)
The Salvation Army (Adults/Children)
United Helpers Mosaic (Adults/Children)
Warren-Washington Association for Mental Health (Adults/Children)

Alliance for Positive Health (Adults)
Catholic Charities Care Coordination Services (Adults)
Citizen Advocates (Adults/Children)
Essex County Mental Health Services (Adults)
Glens Falls Hospital (Adults/Children)
HCR Care Management (Adults/Children)
Hudson Headwaters Health Network (Adults/Children)
Mental Health Association of Essex County (Adults)
RISE Health Housing and Support Services – TSA (Adults/Children)
St. Lawrence Psychiatric Center (Adults)
University of Vermont Health Network/CVPH (Adults)

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