Health Home Care Management Community Referral

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

Type of Referral:

☐ **New Referral** ☐ **Transfer** (Expected date of transfer): _____

Population:

☐ **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/Transfer:

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 Services North (Adults)
☐Champlain Valley Family Center (Adults/Children)
☐Citizen Advocates (Adults/Children)
☐Essex County Mental Health Services (Adults)
☐Fort Hudson Care Management (Adults/Children)
☐HCR Care Management (Adults/Children)
☐Lakeside House (Adults)
☐People USA (Adults)
☐Saratoga Hospital (Adults)
☐Step by Step (Adults)
☐The Salvation Army (Adults/Children)
☐WAIT House (Adults/Children)
☐Alliance for Positive Health (Adults)
☐Catholic Charities Care Coordination Services (Adults)
☐Changed by Christ (Adults)
☐Community Connections of Franklin County (Adults/Children)
☐Families First in Essex County (Children)
☐Glens Falls Hospital (Adults/Children)
☐Hudson Headwaters Health Network (Adults/Children)
☐Mental Health Association of Essex County (Adults)
☐RISE Health Housing and Support Services (Adults/Children)
☐Shelters of Saratoga (Adults)
☐St. Lawrence Psychiatric Center (Adults)
☐United Helpers (Adults/Children)
☐Warren-Washington Association for Mental Health (ASCEND) (Adults/Children)

Please note we cannot guarantee your choice as it depends on capacity, geography, and specialty area.