



Health Home Care Management Community Referral

Phone: 1-866-708-2912

Email: 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

Last Name		First Name			
Medicaid Client ID#		DOB		Sex	
Address	Street _____ Apt. _____				
	Town _____		State _____	Zip _____	
Alt. Address	Street _____ Apt. _____				
	Town _____		State _____	Zip _____	
AKA (also known as)					
Home Phone		Mobile Phone		Alt. Phone	
E-mail address					
Referral Source					
<input type="checkbox"/> Self, family, or friend		<input type="checkbox"/> Primary Care Provider		<input type="checkbox"/> Corrections	
<input type="checkbox"/> Behavioral Health Provider		<input type="checkbox"/> General Hospital ER		<input type="checkbox"/> Other Health Home: (specify) _____	
<input type="checkbox"/> Substance Abuse Treatment Program		<input type="checkbox"/> General Hospital		_____	
		<input type="checkbox"/> Other medical provider			
REFERRAL INFORMATION					
Name				Title	
Agency				Phone	
Initial Eligibility CRITERIA (check all that apply)					
<input type="checkbox"/> Two chronic conditions (specify):					
<input type="checkbox"/> Mental Health Condition (Including Serious Mental Illness [adults] or Serious Emotional Disturbance.)					
<input type="checkbox"/> Substance Use Disorder					
<input type="checkbox"/> Asthma					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Heart Disease					
<input type="checkbox"/> BMI over 25 [adults], at or above 85 th percentile [children]					
<input type="checkbox"/> Other: Specify _____, Specify _____					
OR <input type="checkbox"/> HIV/AIDS					
OR <input type="checkbox"/> Serious Mental Illness [adults] OR Serious Emotional Disturbance [children]					
OR <input type="checkbox"/> Trauma [children]					

APPENDIX A

HEALTH HOME REFERRAL RATIONALE

The Health Home program is designed for Medicaid-eligible people with significant behavioral, medical, or social risk factors which can be addressed through care management. **Please briefly indicate why you believe this individual is appropriate for the Health Home program:**



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

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