

Health Home Adult Enrollment Referral

Section 1: Referral Source Information *(please print)*

Referral Source *(select one)*

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Family/Legal Guardian | <input type="checkbox"/> Self | <input type="checkbox"/> Outpatient Program | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Hospital Unit | <input type="checkbox"/> Ambulatory Medical Service | <input type="checkbox"/> Mobile Crisis Team | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Social Service Agency <i>(specify)</i> | | | |
| <input type="checkbox"/> Other <i>(specify)</i> | | | |

Name of Individual Completing this Form

Referral Date (MM/DD/YYYY)

Referring Agency/Program/Facility

Urgent?

Yes No

Phone No.

()

Fax No.

()

Contact Email

Section 2: Health Home Eligibility

Health Homes aim to help individuals who are in need of an extra hand managing their care. *Appropriateness for a health home* is determined by certain medical, psychiatric, social, and situational criteria.

Check the criteria below that apply for the individual being referred.

Diagnostic Eligibility

(must select one)

- HIV/AIDS *(Single qualifying condition), or*
- Serious Mental Illness (SMI) *(Single qualifying condition), or*
- Sickle Cell Disease *(Single qualifying condition), or*

- Two or more chronic conditions

List chronic qualifying conditions and include ICD-10 codes if available

Medicaid Eligibility *(individual must be enrolled in a Medicaid program)*

- Active Medicaid Fee-for-Service
- Medicaid Managed Care
- Dual eligible (Medicaid/Medicare)

Frequent Utilization Eligibility

- No primary care provider
- No connection to specialty doctor or inadequate connectivity with health care system
- Recent release from incarceration
- Poor compliance with treatment or medication, or difficulty managing medications
- Homeless or inadequate social/family/housing support
- High Utilization of Emergency Department *(3–6 visits in previous year)*

Continued on page 2.



Referring Agency/Program/Facility

Health Home Eligibility continued from page 1.

- Repeated recent hospitalizations (2–3 inpatient stays in previous year)
- Deficits in activities of daily living such as dressing, eating, etc.
- Cannot be effectively treated in an appropriate resourced patient-centered medical home
- Court ordered assisted outpatient treatment
- Recent discharge from psychiatric hospitalization
- Learning or cognition issues

Section 3: Applicant (Patient) Demographics

Applicant Name		Date of Birth (MM/DD/YYYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Applicant Street Address*		City	State	Zip Code
Applicant Home Phone No. ()	Applicant Cell Phone No. ()	Applicant Email		

**If applicant is homeless, provide the shelter/drop-in center location or place he/she may be contacted*

Type of Living Situation

- Private Permanent Residence
- Supported Housing or Supported Single Room Occupancy (SRO)
- Shelter/Emergency Housing
- Homeless/Street Parks/Drop-In Center/Undomiciled
- Other: _____

Medicaid Active? <input type="checkbox"/> Yes Medicaid No. _____ <input type="checkbox"/> No <input type="checkbox"/> Not Known		Managed Care Plan (if applicable)	
Single Point of Access (SPOA) Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Applicant's Primary Care Physician <input type="checkbox"/> Not Known	
Does the Applicant Understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Applicant's Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____	

Section 4: Clinical Information

List Psychiatric Clinical Diagnosis	List General Medical Diagnosis

Referring Agency/Program/Facility

Section 5: Assignment/Notes

Provide the name(s) of health care providers and family contacts. Further expand on the specific need identified on this referral, and the benefit the client would receive from care coordination services.

Please list the best time(s) to reach the Member.

Section 6: Confidentiality

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for the release for further disclosure. New York Public Health Law §2782(5)(a).

Please return this completed Referral to MVP by email to HealthHome@mvphealthcare.com.