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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INSTRUCTIONS:** This form is to be completed in its entirety in order to make a referral to a Health Home. Please attach any clinical documentation to support eligibility. | | | | | | | | | | | |
| TODAY’S DATE: | | | | | DATE OF BIRTH: | | | | | | |
| MEMBERS NAME, (***LAST, FIRST, MI****,) (Include any alias, nicknames or other names the child/youth may be known by)*: | | | | | | | | | | | |
| MEMBERS CURRENT ADDRESS*:* | | | | | | | | | | | |
| CITY: | ZIP: | | | | | | COUNTY OF RESIDENCE: | | | | |
| GENDER:  Male  Female | | | | | | Language preference other than English (IncludING American Sign language): | | | | | |
| MEMBERS HOME PHONE #: | | | MEMBER’S CELL PHONE #: | | | | | | | | |
| **INSURANCE** | | | | | | | | | | | |
| MEDICAID/CIN #: | MCO PLAN NAME: (If any) If copy of Medicaid card available please attach | | | | | | | | | | |
| **PERMISSION TO REFER:** *You must identify that consent to refer has been obtained and who has given consent to refer. Please note that this can be a verbal consent received.* | | | | | | | | | | | |
| PLEASE INDICATE THE INDIVIDUAL FROM WHOM YOU HAVE OBTAINED CONSENT TO REFER THIS MEMBER TO THE HEALTH HOME PROGRAM  Parent  Guardian  Legally authorized representative  member/self/individual if 18 years or older  member/self/individual under 18, but is a parent, pregnant, or married. | | | | | | | | | | DATE PERMISSION TO REFER WAS OBTAINED: | |
| **PARENT/LEGAL GUARDIAN or LEGALLY AUTHORIZED REPRESENTATIVE [I.E. MEDICAL CONSENTER]** | | | | | | | | | | | |
| CONSENTER’S NAME: | | | | RELATIONSHIP TO MEMBER: | | | | | | | |
| CONSENTER’S ADDRESS: | CITY: | | | | | | | STATE: | ZIP CODE: | | GUARDIAN’s PHONE #s: H:  C: |
| CONSENTER’S E-MAIL ADDRESS: | | | | | | | | | | |  |
| **IS MEMBER IN FOSTER CARE?** Yes       NO      Unknown | | | | | | | | | | |  |
| **FAMILY/RESIDENTIAL INFORMATION** | | | | | | | | | | | |
| IS MEMBER’S PARENT/GUARDIAN CURRENTLY ENROLLED IN A HEALTH HOME?  YES  NO  UNKNOWN | | | | | | | | | | | |
| IF YES, FAMILY MEMBER NAME: | | | | RELATIONSHIP TO REFERRED MEMBER: | | | | | | | |
| IF YES, HEALTH HOME NAME: | | | | IF YES, CARE MANAGEMENT AGENCY: | | | | | | | |
| **HEALTH HOME ELIGIBILITY CRITERIA** **(\* Note:** *if documentation is available to support any of these conditions please attach)* | | | | | | | | | | | |
| **ELIGIBILITY TYPE**  ***(if ICD10 code available please provide)*** | | **APPROPRIATENESS CRITERIA *(Check all that apply)***  At risk for adverse event (death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)  Has inadequate social/family/housing support or serious disruptions in family relationships  Has inadequate connectivity with healthcare system  Does not adhere to treatments or has difficulty managing medications  Has recently been released from incarceration, placement, detention, or psychiatric hospitalization  Has deficits in activities of daily living, learning or cognition issues  Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home | | | | | | | | | |
| Two or More Chronic Conditions. List Conditions:  1.  2.  **OR one of the following single qualifying conditions**  Serious Emotional Disturbance (SED)  List condition:      **OR**  complex trauma **OR**  HIV/AIDS | |  | | | | | | | | | |
| **REFERRAL SOURCE:** | | | | | | | | | | | |
| Hospital  MCP  VFCA  LDSS  Preventive Services  Community Based Organization  School  Primary Care Physician  Mental Health Provider  Specialist  LGU  SPOA  Other Referral Source: | | | | | | | | | | | |
| REFERRAL ORGANIZATION: | NAME OF PERSON MAKING REFERRAL: | | | | | | | | | | |
| PERSON MAKING REFERRAL CONTACT INFO:  PHONE:       E-MAIL: | | | | | | | | | | | |
| PREFERRED OR RECOMMENDED HEALTH HOME (SEE LIST ATTACHED: | | | | | | | | | | | |