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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:       |