Children's Health Home Care Management Referral Form

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)
☐ 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

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

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: