ST PETER'S HEALTH PARTNERS

CRHC Use Only:
Received: _____
HARP? ☐ Yes ☐ No

CAPITAL REGION HEALTH CONNECTIONS– *A Health Home serving Albany, Rensselaer and Schenectady Counties*

REFERRAL FORM

*Complete this form and send to Capital Region Health Connections via **secure** email at HealthHome@sphp.com or fax to 518-271-5009, Attention: **Health Home Referral.***

To discuss possible referrals, phone contact can be made at 518-271-3301.

Referral Information	
Date of referral:	
Agency making referral:	
Name and contact information of person making referral:	

Recipient's Demographic Information			
Name:			
Address:			
Phone Number:			
Medicaid CIN: REQUIRED		DOB:	
Managed Care Organization:	☐ CDPHP ☐ MVP ☐ Fidelis ☐ Wellcare ☐ Unknown ☐ Other, specify:		

Recipient Information	
Recipient's current living situation:	☐ Currently homeless ☐ At risk of homelessness ☐ Currently has housing ☐ Unknown
Primary Diagnosis and ICD 10 Code:	
Has the Recipient ever experienced an incarceration?	☐ Yes ☐ No ☐ Unsure If yes, please provide release date:
Has the Recipient experienced a recent hospitalization due to mental illness?	☐ Yes ☐ No ☐ Unsure If yes, please provide discharge date:
Has the Recipient experienced a recent inpatient stay for substance abuse treatment?	☐ Yes ☐ No ☐ Unsure If yes, please provide discharge date:

If Recipient is currently inpatient at a hospital or another facility other than a residential setting:	
Facility Name:	
Anticipated Date of Discharge:	
Any additional information on current setting:	

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Recipient has the following qualifying conditions: *Check **ALL** that apply*			
Two chronic Health Conditions		**OR**	**One Qualifying Chronic Condition**
☐ Mental Health	☐ Substance Abuse		☐ HIV / AIDS
☐ Asthma	☐ Diabetes		
☐ Heart Disease	☐ Overweight		☐ Serious Mental Illness
☐ Other, specify:			

****Please Include with the Referral****
☐ Most recent copy of psychological, psychiatric or medical evaluation and/or treatment plan.
☐ Your agency's release of information for Capital Region Health Connections.

Appropriateness for Health Home Services *Check all that apply*	
☐ Lack of or inadequate social / family / housing support	☐ Learning or cognition issues
☐ Lack of or inadequate connectivity with healthcare system	☐ Deficits in activities of daily living (e.g., dressing, eating)
☐ Non-adherence to or difficulty managing treatment(s) or medication(s)	☐ Repeated recent hospitalizations or ER visits for preventable conditions
☐ Probable clinical risk or adverse event (e.g., death, disability, inpatient, nursing home admission)	☐ Recent release from incarceration or psychiatric hospitalization

Reason for Referral *Please provide a more detailed reason for the Health Home referral*

Safety Concerns ***Please check or specify any concerns that you are aware of and provide any additional information that may be helpful for staff making a home visit.***		
☐ History of Aggressive Behavior	☐ Access to Firearms	☐ Infestation (Bed Bugs, etc.)
☐ Home-based Safety Concerns	☐ Registered Sex Offender	☐ Risk to Self
☐ Other, specify:		
Additional Information:		