*Please complete this form as best you can and submit the form along with a copy of the DOH 5055 listing the local SPOA/LGU to your local SPOA/LGU contact. Please do not hand write forms.*

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| --- | --- |
| **Member Information** | **Referral Source Information** |
| Name: | Date of Referral / Request: |
| DOB: | Name: |
| Medicaid CIN: | Title: |
| Address: *(Please include facility name, if applicable)* | Agency: |
|  | Email: |
|  | Telephone: |
| Living Situation: Choose an item. |  |
| SMI Diagnosis: | DLA 20 Score: |

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| **Education Level** | **Current Employment Status** | **Number of Hours Worked Per Week** |
| Choose an item. | Choose an item. | Choose an item. |

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| **Rising Risk: Variables to Consider for Referral**  *Please provide your best estimates over the past 180 days*  *If you do not know the information, you may leave it blank. If the number of contacts/days is zero, please record zero* | |
| Number of Police Contacts: | Number of Chemical Dependency Crisis Contacts: |
| Number of Court Appearances: | Number of Chemical Dependency Detox Contacts: |
| Number of ED visits (medical): | Number of Shelter Days: |
| Number of ED/Crisis visits (mental health): | Number of Days not in the Community: |
| Number of Ambulance Trips: |  |

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| **Rationale for HH+ Services**  *Please provide a detailed reason why the Member is in need of HH+ Services. Please be sure to include previous supports or services that have been unsuccessful in mitigating need. Attach any supporting documentation.* |
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| **Anticipated Goals / Objectives / Outcomes**  *Please provide a description of what will be worked on with the Member to address the needs listed above.*  *Please attach the Member's most recent Health Home Plan of Care.* |
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| **Alerts / Safety Concerns** |
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| **Medical Conditions**  *Please list any known medical conditions or special needs, OR attach the Member's Problem list from CareManager.* |
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| **Persons Affiliated with the Member** | |
| **Name** | **Affiliation** |
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| **Risk Assessment**  *Please rate the overall risk of the Member* | |
| 1. None | **Key:**  1. None=Stabilized at baseline; symptoms and stressors well managed by current treatment and supports.  2. Low=Experiencing some mental health symptoms and life stressors.  3. Moderate=Requires additional community supports and/or is currently experiencing problematic symptoms or stressors.  4. High Alert=Requires intensive support. Absence of intensive supports will likely require hospitalization.  5. Imminent=Severe risk, unsafe in the community. Requires secure inpatient program, hospitalization. |
| 2. Low |
| 3. Moderate |
| 4. High Alert |
| 5. Imminent |
| 6. Unknown |

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| **Hospitalizations**  *Please record the number of days the Member has been hospitalized or in placement at a Mental Health facility in the past 180 days* | | | | | |
| 0 Days | 1-5 Days | 6-10 Days | 11-25 Days | 26+ Days | Unknown |

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| **Incarceration**  *Please record the number of days the Member was incarcerated in the past 180 days* | | | | | |
| 0 Days | 1-5 Days | 6-10 Days | 11-25 Days | 26+ Days | Unknown |

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| **Substance Abuse Impairment Scale** | |
| Choose an item. | Specify Drug of Choice and Use Patterns: |

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| **Other / General Comments**  *Please provide any other information that may be applicable to the decision and attach any supporting documentation.* |
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**Care Coordinator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Supporting Documentation Attached** | |
| Health Home Plan of Care (Required) | Attached |
| Health Home 5055 Consent (Required) | Attached |
| Problems List from CareManager (Required if Medical Conditions not listed in this form) | Attached **OR**  Medical Conditions listed |
| Documents supporting the rationale for HH+ level of service | Attached (optional) |
| DLA 20 Assessment, if applicable | Attached  N/A |

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| ***LGU/SPOA Use Only*** | |
| LGU/SPOA Approval:  Yes  No | Name and Title of Representative: |
| Date of Approval/Denial: | Signature: |
| Justification for Approval/Denial: | |