*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.*

|  |  |
| --- | --- |
| **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: |

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

|  |
| --- |
| **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:  |  |

|  |
| --- |
| **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.* |
|  |

|  |
| --- |
| **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.* |
|  |

|  |
| --- |
| **Alerts / Safety Concerns** |
|  |

|  |
| --- |
| **Medical Conditions***Please list any known medical conditions or special needs, OR attach the Member's Problem list from CareManager.* |
|  |

|  |
| --- |
| **Persons Affiliated with the Member** |
| **Name** | **Affiliation** |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **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 [ ]  |

|  |
| --- |
| **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 |

|  |
| --- |
| **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 |

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

|  |
| --- |
| **Other / General Comments***Please provide any other information that may be applicable to the decision and attach any supporting documentation.* |
|  |

**Care Coordinator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

|  |
| --- |
| **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 |

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