**REFERRAL FORM**

*Complete this form and send to Capital Region Health Connections via* ***secure*** *email at* [*HealthHome@sphp.com*](mailto: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: | Click here to enter a date. |
| Agency making referral: | Click here to enter text. |
| Name and contact information of person making referral: | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Recipient’s Demographic Information** | | | |
| Name: | Click here to enter text. | | |
| Address: | Click here to enter text. | | |
| Click here to enter text. | | |
| Phone Number: | Click here to enter text. | | |
| **Medicaid CIN:**  **REQUIRED** | Click here to enter text. | DOB: | Click here to enter a date. |
| Managed Care Organization: | CDPHP  MVP  Fidelis  Wellcare  Unknown  Other, specify: Click here to enter text. | | |

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

|  |  |
| --- | --- |
| **If Recipient is currently inpatient at a hospital or another facility other than a residential setting:** | |
| Facility Name: | Click here to enter text. |
| Anticipated Date of Discharge: | Click here to enter a date. |
| Any additional information on current setting: | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: Click here to enter text. | |

|  |
| --- |
| **\*\*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* |
| Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| **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: Click here to enter text. | | |
| Additional Information: Click here to enter text. | | |