**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.*

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| **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. |

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| **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.  |

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| **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 [ ]  UnsureIf 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 [ ]  UnsureIf 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 [ ]  UnsureIf yes, please provide discharge date: Click here to enter a date. |

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| **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. |

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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: Click here to enter text. |

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| **\*\*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. |

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| **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 |

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| **Reason for Referral**  *Please provide a more detailed reason for the Health Home referral* |
| Click here to enter text. |

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| **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. |