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| **Name DOB** |
| **Contact Info/Phone Number Health Insurance /Medicaid #** |
| **Address/Location** |
| **If we cannot get in contact with you, when and where do you hang out? Where do you eat meals?** |
| **If we cannot get in contact with you to schedule the intake interview, who else can we contact?** |
| **Primary Language Gender** |
| **Highest Level of Education Completed Race** |
| **Legal Status** (circle one)Citizen Legal Alien-Eligible Legal Alien-Ineligible Undocumented |
| **Referral Source and Referral Contact Information:** |
| **List any other providers you are working with (including Health Home Care Coordinator/Agency and/or Managed Care Agency):** |

**Referral Criteria**

* **Applicant is homeless**

**AND**

* **Applicant is enrolled in Health Home**

**OR**

* **Referring Provider is working to enroll the eligible member in a Health Home**

**IN ADDITION, IN THE LAST 12 MONTHS HAS HAD ONE OF THE FOLLOWING:**

* **Two or more inpatient stays**
* **Five or more emergency department visits**
* **Four or more emergency department visits and one or more inpatient stay**
* **Base period Medicaid spending above the top 20% of Medicaid recipients’ relative to the county of fiscal responsibility and target population parameters**

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| **Please briefly describe hospital use over the last 6-9 months (including Emergency Room and Inpatient Mental Health and Substance Abuse):** |
| **Please briefly describe homeless status (minimum of last three years):** |
| **Please briefly describe (if any):**  **Mental Health Diagnosis:**  **Substance Abuse Diagnosis:**  **Physical Health Diagnosis:** |

Participant Print Name Participant Sign Name Date