*Complete this form and send to Community 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.*

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| **Referral Information** | |
| Date of referral: |  |
| Agency making referral: |  |
| Name and contact information of person making referral: |  |
| Was a SPOA application also completed for recipient? | Yes  No  Unsure |

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| **Recipient’s Demographic Information** | | | | |
| Name: |  | Preferred Pronouns: | |  |
| Address: |  | Phone Number: | |  |
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| **Medicaid CIN:**  **REQUIRED** |  | DOB: |  | |
| Managed Care Organization: | CDPHP  MVP  Fidelis  UHC  Molina  Excellus  Unknown | | Needs Translation Services?  Yes  No | |

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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: |  |
| Has the Recipient ever experienced an incarceration? | Yes  No  Unsure  If yes, please provide release date: |
| Has the Recipient experienced a recent hospitalization due to mental illness? | Yes  No  Unsure  If yes, please provide discharge date: |
| Has the Recipient experienced a recent inpatient stay for substance abuse treatment? | Yes  No  Unsure  If yes, please provide discharge date: |

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| **If Recipient is currently inpatient at a hospital or another facility other than a residential setting:** | |
| Facility Name: |  |
| Anticipated Date of Discharge: |  |
| Additional information on current setting: |  |

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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 | Serious Mental Illness |
| Heart Disease | Overweight | Sickle Cell Disease |
| Other, specify: | |

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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 Community 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* |
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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: | | |
| Additional Information: | | |

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