*Complete this form and send to Community 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: |  |
| 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 [ ]  UnsureIf yes, please provide release date:  |
| Has the Recipient experienced a recent hospitalization due to mental illness? | [ ]  Yes [ ]  No [ ]  UnsureIf yes, please provide discharge date:  |
| Has the Recipient experienced a recent inpatient stay for substance abuse treatment? | [ ]  Yes [ ]  No [ ]  UnsureIf 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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