



Please fax to: 607-240-2898

Attention: Nicole/Katie/MHH Program

5802629 - UHS MHH (Medicaid Health Home) Referral for Care Coordination

Name	Date of Birth	Medicaid Gender
Address	Medicaid CIN #	
	Pending <input type="checkbox"/> Active <input type="checkbox"/>	
	County of Residence	
Phone Number		
Referring Agency and Contact Person to be made aware of referral determination. Include contact information.		
Indicate any need for language / interpretation services (specify language)		

Eligibility Category Information - check all that apply
 (Individual must meet A OR B OR two C's to be eligible for Health home Care Coordination)

<input checked="" type="checkbox"/>	Category	Specify Diagnosis / Available Details
<input type="checkbox"/>	A Serious Mental Illness	
<input type="checkbox"/>	B HIV / AIDS	
<input type="checkbox"/>	C Mental Health Condition	
<input type="checkbox"/>	C Substance Abuse Disorder	
<input type="checkbox"/>	C Asthma	
<input type="checkbox"/>	C Diabetes	
<input type="checkbox"/>	C Heart Disease	
<input type="checkbox"/>	C Hepatitis C	
<input type="checkbox"/>	C Obesity (BMI > 25)	
<input type="checkbox"/>	C Other chronic conditions (specify)	

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List known Medical, Behavioral and / or Substance Use Treatment Providers (previous or current):

**Care Coordination Needs
Check all that apply**

✓	Category	Factors Requiring Care Coordination
	No primary care practitioner (PCP)	
	Probable risk for adverse event related to medical, mental health, and / or substance use issue	
	Poor compliance (does not keep appointments, has difficulty managing medications, etc)	
	No connection to specialty doctor or other practitioner for their condition	
	Inappropriate Emergency Department use	
	Repeated recent hospitalization for preventable conditions either medical or psychiatric	
	Recent release from Psychiatric or Chemical Dependency hospitalization	
	Recent release from incarceration	
	Cannot be effectively treated in an appropriately resourced patient centered medical home	
	Homelessness	
	Lack of or inadequate social/family/housing support	

Narrative - Provide any additional information that may be helpful for care coordination and/or the presenting need/concerns related to this individual without care coordination services in place.

Signature of Person Completing Form: _____ Date/Time: _____

-----For Internal UHS MHH Care Coordination Only-----

Accepted <input type="checkbox"/> Rejected <input type="checkbox"/>	Assigned CMA:	Date Assigned:
Date Communicated to Referral:		