CONFIDENTIAL

Adult Health Home Referral/Eligibility Form

Applicants must be actively enrolled in Medicaid Fee for Service (FFS) or in Managed Medicaid (MM), have a qualifying condition(s), and benefit from Care Coordination services. Please complete this confidential form to confirm the member's eligibility.

Visit our website for a copy of CBC's Health Home Consent, a full listing of our Network Providers and MCO Plan Contacts: http://www.cbcare.org/

If member resides with a child and is interested in connecting the child to services, refer to the HHSC Referral Eligibility Form available on our website.

For assistance with completing this form please call 646-930-8823 or 866-899-0152.

Today's Date:

MEMBER INFORMATION

Member's Name: [Last]	[First]	[Middle]	Date of Birth:	Sex:	Gender:

(If applicant is homeless, note the shelter/drop –in center or place where the applicant may be contacted)

Street Address:	City/State	Zip Code:

Apartment/Unit#:	Home phone:	Cell phone:	Email address:

Preferred Contact Method: ☐ Home Phone ☐Cell Phone ☐Email

Language Preference other than English:

Do you have a legal representative: ☐ Yes ☐ No If Yes, Name and Contact Information:

Current Living Situation:

□ Private/Permanent Residence □ Supportive Housing or Supported SRO

□ Temporary or Unstable Housing □ Street Homeless

□ Drop In-Shelter or ER Housing □ Other_____

List people that reside with member and their relationship to member: _____

PCP INFORMATION

Physician Name/Health Center:	Address:	Phone Number:	Fax Number:

MEDICAID /MANAGED CARE INFORMATION

Medicaid ID number: _____ ☐Active ☐Inactive ☐ Unknown

Medicare/Dual: ☐ Yes ☐ No ☐ Fee For Service ☐Managed Care Plan: _____

REFERRAL SOURCE

☐Hospital ☐ MCO ☐Primary Care Physician/Specialist ☐ Mental Health Provider ☐Foster Care Agency ☐Other:_____

Referral Source Organization:	Referral Source Name/Title:	Referral Source Contact Number:

Referral Source Email:

HEALTH HOME ELIGIBILITY /APPROPRIATENESS CRITERIA (NOTE: If documentation is available to support any of these conditions please attach)

Member's Diagnoses: □ Two Chronic Conditions* □ Serious Mental Illness (SMI) □ HIV/AIDS □ Sickle Cell Disease (SCD)

LIST TWO OR MORE CHRONIC CONDITIONS AND/OR SERIOUS SMI: _____

Qualifying chronic conditions include: mental health condition (SMI), substance abuse disorder, asthma, diabetes, heart disease, a BMI over 25, and other chronic conditions described in detail in the New York State Medicaid State Plan Amendment 11-56, which can be accessed on the New York State Department of Health's Medicaid Health Home website.

MEMBER HAS SIGNIFICANT BEHAVIORAL, MEDICAL, OR SOCIAL RISK FACTORS (NEEDS) WHICH CAN BE IMPROVED THROUGH CARE COORDINATION SERVICES. (PLEASE CHECK ALL THAT APPLY)

☐ Has inadequate connectivity to health care system (PCPs, specialty MDs, etc.)
☐ Does not adhere to treatment or medication or has difficulty managing medication
☐ Recent release from incarceration or psych hospitalization
☐ Member has difficulty keeping appointments
☐ Has inadequate social, family, or housing support
☐ Homelessness
□ Learning or Cognitive issues
□ Deficits in Activities of Daily Living
□ Probable risk for an adverse event
□ Involvement with Criminal Justice System
□ Frequent ER/Hospital utilization

CBC COORDINATED BEHAVIORAL CARE

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IMMEDIATE NEEDS:

Do you have any urgent needs today?

- ☐ Housing/Need a place to stay
- ☐ Medication concerns
- ☐ Food
- ☐ Utilities (e.g., heat, A/C, electric, telephone, water)
- ☐ Transportation
- ☐ Child care
- ☐ Benefits/Entitlements
- ☐ Severe pain/Medical concerns
- ☐ Safety (yours or that of your family)
- ☐ Thoughts of hurting yourself or others today or within the past 30 days
- ☐ Other, specify: _____

ADDITIONAL INFORMATION:

Is there anything else you want to tell me today?

_____

_____

_____

_____

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_____

_____

Where is the best place to meet you or a way for me to contact you?

_____

_____

_____

_____

Observations: (*please note additional information that might be helpful in following up with this client*)

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_____

Print Name of person completing form:_____ **Signature of person completing form:**_____