ABBOTT HOUSE
Building Stronger Families and Communities since 1963

Health Home Referral and Eligibility Application Form

Abbott House is accepting referrals from the community for enrollment of eligible children/youth into Health Home Services. Children/Youth must meet all eligibility requirements to be considered for enrollment.

HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY

1. Child/youth currently has active Medicaid; AND
2. Child/youth meets the NYS Department of Health Eligibility Criteria:

   Two or more Chronic Conditions (Substance Use Disorder, Asthma, Diabetes);

   OR

   One Single Qualifying Chronic Condition

   1. HIV/AIDS; **OR**
   2. Serious Emotional Disturbance **OR**
   3. Complex Trauma
3. Child/youth meet the appropriateness criteria such as has significant behavioral, medical or social risk factors which can be addressed through care coordination.

HOW TO MAKE A REFERRAL

1. Complete the attached Universal Referral and Eligibility Application Form, including as much detail as possible to allow us to verify eligibility for health home.
2. Attach supporting documentation of diagnosis (if available).
3. Approved children/youth will be assigned to a Care Manager who will conduct outreach and attempt to engage the child/youth in health home care management services.
4. Health Home services are voluntary and the Youth and/or Parent/Legal Guardian will be asked to consent during the outreach and engagement process.
5. Send the completed application and consent via secure email or fax, or mail to:

Abbott House
Donya Locke, CM Supervisor
100 North Broadway, Irvington NY 10550
Irv: *914 591 7300 x13269*
Bronx: 718 329 4968 x13456
Cell: 914 327 1986 **e-Fax:** 914 400 2814
dlocke@abbotthouse.net
www.abbotthouse.net

HEALTH HOME EFERRAL & ELIGIBILTY APPLICATION FORM

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INSTRUCTIONS: This form is to be completed in its entirety in order to make a referral to a Health Home. Please attach any clinical documentation to support eligibility.

TODAY'S DATE:	DATE OF BIRTH:
MEMBERS NAME, (***LAST, FIRST, MI,***) *(Include any alias, nicknames or other names the child/youth may be known by)*:	
MEMBERS CURRENT ADDRESS*:*	

CITY:	ZIP:	COUNTY OF RESIDENCE:

GENDER: ☐ Male ☐ Female	LANGUAGE PREFERENCE OTHER THAN ENGLISH (INCLUDING AMERICAN SIGN LANGUAGE):
MEMBERS HOME PHONE #:	MEMBER'S CELL PHONE #:

INSURANCE

MEDICAID/CIN #:	MCO PLAN NAME: (If any) **If copy of Medicaid card available please attach**

PERMISSION TO REFER: *You must identify that consent to refer has been obtained and who has given consent to refer. Please note that this can be a verbal consent received.*

PLEASE INDICATE THE INDIVIDUAL FROM WHOM YOU HAVE OBTAINED CONSENT TO REFER THIS MEMBER TO THE HEALTH HOME PROGRAM ☐Parent ☐ Guardian ☐ Legally authorized representative ☐ member/self/individual if 18 years or older ☐ member/self/individual under 18, but is a parent, pregnant, or married.	DATE PERMISSION TO REFER WAS OBTAINED:

PARENT/LEGAL GUARDIAN or LEGALLY AUTHORIZED REPRESENTATIVE [I.E. MEDICAL CONSENTER]

CONSENTER'S NAME:	RELATIONSHIP TO MEMBER:			
CONSENTER'S ADDRESS:	CITY:	STATE:	ZIP CODE:	GUARDIAN's PHONE #s: H: C:
CONSENTER'S E-MAIL ADDRESS:				
IS MEMBER IN FOSTER CARE? Yes NO Unknown				

FAMILY/RESIDENTIAL INFORMATION

IS MEMBER'S PARENT/GUARDIAN CURRENTLY ENROLLED IN A HEALTH HOME? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, FAMILY MEMBER NAME:	RELATIONSHIP TO REFERRED MEMBER:
IF YES, HEALTH HOME NAME:	IF YES, CARE MANAGEMENT AGENCY:

HEALTH HOME ELIGIBILITY CRITERIA (* Note: *if documentation is available to support any of these conditions please attach)*

ELIGIBILITY TYPE
(if ICD10 code available please provide)

☐ Two or More Chronic Conditions. List Conditions:
1.
2.

OR one of the following single qualifying conditions

☐ Serious Emotional Disturbance (SED)
List condition: ____**OR**
☐ complex trauma **OR**
☐ HIV/AIDS

APPROPRIATENESS CRITERIA *(Check all that apply)*

☐ At risk for adverse event (death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
☐ Has inadequate social/family/housing support or serious disruptions in family relationships
☐ Has inadequate connectivity with healthcare system
☐ Does not adhere to treatments or has difficulty managing medications
☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
☐ Has deficits in activities of daily living, learning or cognition issues
☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

REFERRAL SOURCE:

☐ Hospital ☐ MCP ☐ VFCA ☐ LDSS ☐ Preventive Services ☐ Community Based Organization ☐ School
☐ Primary Care Physician ☐ Mental Health Provider ☐ Specialist ☐ LGU ☐ SPOA ☐ Other Referral Source:

REFERRAL ORGANIZATION:	NAME OF PERSON MAKING REFERRAL:

PERSON MAKING REFERRAL CONTACT INFO:

PHONE: E-MAIL:

PREFERRED OR RECOMMENDED HEALTH HOME (SEE LIST ATTACHED: