St. Mary's Health Care
Health Home Serving Adult Referral (21+)
Fax: 518-770-7511
E-Mail: HealthHome@nysmha.org

Thank you for your referral to St. Mary's HealthCare Health Home. To process and assign members in a timely manner, the referral must contain the following but not limited to:
A complete and most up to date referral
Most recent medical evaluation, psychosocial evaluation, or psychiatric evaluation that outlines the current diagnosis that will be used to determine qualifying criteria into the health home.
Signed and attached Consent for Disclosure of Health Information Form

***** PLEASE NOTE THAT INCOMPLETE REFERRALS OR REFERRALS MISSING THE REQUIRED SUPPORTING DOCUMENTATION WILL BE RETURNED TO THE REFERRAL SOURCE AND MAY DELAY PROCESSING FOR ENROLLMENT**********

Name:	DOB:	Phone Number:
Address:		
Language Preference: ☐ English ☐ Spanish Other: _____		
Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Unknown		

Insurance: Individual must have active Medicaid to be eligible for Health Home	
Medicaid CIN:	Social Security Number:
Medicaid Managed Care Organization Name: ☐ Fidelis ☐ CDPHP ☐ Other _____	
County of Residence: ☐ Fulton ☐ Montgomery Other: _____	

Eligibility Criteria: Must attach supporting documentation to referral for criteria used to determine eligibility for enrollment to the Health Home Program
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

Eligibility Criteria:	☐ 2 Chronic Medical Conditions OR ☐ Single Qualifying Serious Mental Illness ☐ HIV/AIDS ☐ Sickle Cell

ICD Code	**Diagnosis**	**Name of Supporting Documentation Attached**
1.		
2.		
3.		
4.		

Advance Directives in Place, if Yes please attach:	**Yes**	**No**	**Unknown**

Considerations for Health Home Eligibility: Please check all that apply:

☐ At risk for adverse event (i.e.. Death, disability, inpatient or nursing home admission, mandated preventive services, etc.)	☐ Recently released from incarceration or psychiatric hospitalization
☐ Lack of or inadequate social/family/housing/support	☐ Recent hospitalization for preventable conditions
☐ Lack of or inadequate connectivity with healthcare system	☐ Recent and repeated ED visits for preventable or PCP managed conditions
☐ Does not adhere to or has difficulty managing treatment and medications	☐ Deficits in activities of daily living, learning, or cognition issues

Additional Information

Current Living Situation: ☐ Homeless ☐ Stable Housing ☐ Risk of Homelessness
Recent Incarceration: ☐ Yes/Date of Discharge: _____ ☐ No AOT Order: ☐ Yes ☐ No Jail Transition Program: ☐ Yes ☐ No
Recent psychiatric hospitalization: ☐ Yes/Date of Charge: _____ ☐ No
Recent substance abuse hospitalizations: ☐ Yes/Date of Discharge: _____ ☐ No

Safety Concerns to be aware of during home visits:

☐ Access to firearms ☐ Registered Sex Offender ☐ History of Aggressive Behavior ☐ Infestation (ex. Bed bugs) ☐ Domestic Violence ☐ Other _____

Please provide a detailed reason for the referral

Referral Source:

Referral Organization:
Type of organization i.e. Hospital, MCO, Specialist, Mental Health Provider etc
Person making referral/title:
Phone Number:
Email:

_____ **_____**

Signature **Date**

CONSENT TO THE DISCLOSURE OF SUPPORTING DOCUMENTATION FORM
PERMISSION TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION FOR THE USE OF CARE COORDINATION ASSIGNMENT

By signing this Consent Form, you permit parties completing a referral on your behalf to share your health information so that your Health Home can have a complete picture of your health and help connect you to better care. Your health records provide information to determine your eligibility for the Health Home program. Your health records provide information about your illnesses injuries, diagnoses, medication and/or test results. Your records may include sensitive information.

If you permit disclosure, your health information will be used to assist in Care Coordination related to your health and social services needs. Your health information may be re-disclosed only as permitted by state and federal laws and regulations These laws limit re-disclosure of information about your treatment at a substance use or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information to the SMH Health Home Program will not be the basis for denial of health services or health insurance. Your choice to give or deny consent is solely for the purpose of obtaining supporting documentation to determine eligibility for the Health Home Program. If you choose not to consent into the Health Home program after a referral has been submitted on your behalf, the Health Home Program is not required to return this information or remove it from their records. You are entitled to a copy of this consent form after you sign it.

CONSENT TO THE DISCLOSURE OF SUPPORTING DOCUMENTATION

1. The person whose information may be used or disclosed is:

   Name: _____Date of Birth: _____
2. The information included in the supporting documentation that will be disclosed to the Health Home Program is for the purpose of determining eligibility for Health Home services and ongoing care coordination. The information that will be disclosed includes records of diagnosis and health care treatment, which could include but not limited to, Mental Health records, Substance Use Treatment records, HIV related information, Genetic information, and information about sexually transmitted diseases.
3. This information will be disclosed to the Care Management Agency (CMA) in which you are assigned to receive Care Coordination services. St Mary's Healthcare Health Home works with Alliance for Positive Health, Building Blocks, Catholic Charities Care Coordination Services, St. Anne Institute, St. Mary's Care Management Agency, and Salvation Army.
4. Use and disclosure of this information is permitted only as necessary for the purposes of Care Coordination Services including outreach, referrals, individualized care planning and monitoring of the quality of service.
5. I understand that I can choose not to pursue Care Coordination services at any time. I also understand that records disclosed with this "Consent to the Disclosure of Supporting Documentation" may not be retrieved. Any person or organization that relied on the supporting documentation may continue to use or disclose that information as needed to complete services.

I authorize the use and disclose of my personal information as described in this document and consent to the referral to the St. Mary's Healthcare Health Home Program.

_____ _____
Signature of Individual/Parent/ Guardian/Legally Authorized Representative Date

_____
Relationship to Referred Member