



PLEASE FAX TO:
 UHS Medicaid Health Home
 607-240-2898

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

Name: _____	DOB: _____	Medicaid Gender: _____
Address: _____	Medicaid CIN #: _____	
	<input type="checkbox"/> Excellus <input type="checkbox"/> Fidelis <input type="checkbox"/> Fee-For-Service	
	Please Indicate: <input type="checkbox"/> HARP Enrolled <input type="checkbox"/> HARP Eligible <input type="checkbox"/> HH+ Eligible	
	County of Residence: <input type="checkbox"/> Broome <input type="checkbox"/> Chenango <input type="checkbox"/> Tioga	
Phone Number: _____		
Referral Name: _____ Phone: _____ Referring Organization: _____ E-mail: _____		
Specify Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Preferred or Recommended Care Management Agency: _____		

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)

		Category	Specify Diagnosis / Available Details
	A	Serious Mental Illness	
	B	HIV/ AIDS	
	C	Mental Health Condition	
	C	Substance Abuse Disorder	
	C	Asthma	
	C	Diabetes	
	C	Heart Disease	
	C	Hepatitis C	
	C	Obesity (BMI > 25)	
	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:
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