Health Home Upward Enrollment Referral

Section 1: Referral Source Information *(please print)*

Referral Source *(select one)*

- ☐ Family/Legal Guardian
- ☐ Self
- ☐ Outpatient Program
- ☐ Shelter
- ☐ Hospital Unit
- ☐ Ambulatory Medical Service
- ☐ Mobile Crisis Team
- ☐ Emergency Room
- ☐ Social Service Agency *(specify)* _____
- ☐ Other *(specify)* _____

Referring Agency/Program/Facility	Urgent? ☐ Yes ☐ No	*(MVP Use Only)* ☐ Enrollment Optimization?

Phone No.	Fax No.	Contact Email

Section 2: Health Home Eligibility

Health Homes aim to help individuals who are in need of an extra hand managing their care. *Appropriateness for a health home* is determined by certain medical, psychiatric, social, and situational criteria.

Check the criteria below that apply for the individual being referred.

Diagnostic Eligibility *(must select one)*

- ☐ One serious persistent mental health condition
- ☐ Two or more chronic conditions
- ☐ HIV/AIDS

Medicaid Eligibility *(individual must be enrolled in a Medicaid program)*

- ☐ Active Medicaid Fee-for-Service
- ☐ Medicaid Managed Care
- ☐ Dual eligible (Medicaid/Medicare)

Frequent Utilization Eligibility

- ☐ No primary care provider
- ☐ No connection to specialty doctor or inadequate connectivity with health care system
- ☐ Recent release from incarceration
- ☐ Poor compliance with treatment or mediation, or difficulty managing medications
- ☐ Homeless or inadequate social/family/housing support
- ☐ High Utilization of Emergency Department *(3–6 visits in previous year)*
- ☐ Repeated recent hospitalizations *(2–3 inpatient stays in previous year)*
- ☐ Deficits in activities of daily living such as dressing, eating, etc.
- ☐ Cannot be effectively treated in an appropriate resourced patient-centered medical home
- ☐ Court ordered assisted outpatient treatment
- ☐ Assertive community treatment
- ☐ Recent discharge from psychiatric hospitalization
- ☐ Learning or cognition issues

Continued on page 2.

Referring Agency/Program/Facility

Section 3: Applicant (Patient) Demographics

Applicant Name | Date of Birth *(MM/DD/YYYY)* | Gender ☐ Male ☐ Female

Applicant Street Address* | City | State | Zip Code

Applicant Home Phone No. | **Applicant** Cell Phone No. | **Applicant** Email

**If applicant is homeless, provide the shelter/drop-in center location or place he/she may be contacted*

Type of Living Situation

- ☐ Private Permanent Residence
- ☐ Supported Housing or Supported Single Room Occupancy (SRO)
- ☐ Shelter/Emergency Housing
- ☐ Homeless/Street Parks/Drop-In Center/Undomiciled
- ☐ Other: _____

Medicaid Active?
☐ Yes Medicaid No. _____ ☐ No ☐ Not Known

Medicare/Dual?
☐ Yes ☐ No

Managed Care Plan *(if applicable)*

Single Point of Access (SPOA) Completed?
☐ Yes ☐ No

Applicant's Primary Care Physician
☐ Not Known

Does the Applicant Understand English?
☐ Yes ☐ No

Applicant's Primary Language
☐ English ☐ Spanish ☐ French ☐ Russian ☐ Other: _____

Section 4: Clinical Information

List Psychiatric Clinical Diagnosis	List General Medical Diagnosis

Section 5: Assignment/Notes

Provide the name(s) of health care providers and family contacts. Further expand on the specific need identified on this referral, and the benefit the client would receive from care coordination services.

Section 6: Confidentiality

This information has been disclosed to you from confidential records, which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence, or both. A general authorization for the release of medical or other information is not sufficient for further disclosure. New York State Public Health Law, Article 27-F §2782 5. (a).

Name of Person Completing this Referral

Please return this completed Referral to MVP by fax to **914-372-2472** or email to **HealthHome@mvphealthcare.com**.