UHS

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

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

Name	Date of Birth	Medicaid Gender ◯ Male ◯ Female
Address	Medicaid CIN # _____ ☐ Excellus ☐ Fidelis ☐ Fee-For-Service	
	Please Indicate: ☐ HARP Enrolled ☐ HARP Eligible ☐ HH+ Eligible	
	County of Residence: ☐ Broome ☐ Chenango ☐ Tioga	
	Phone Number: _____	
Referral Name: _____ Referring Organization: _____	Phone: _____ E-mail: _____	
Specify Language: ☐ English ☐ Spanish ☐ 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 ☐ Rejected ☐	**Assigned CMA:**	**Date Assigned:**