



Health Home Care Coordination Referral Assessment

Demographic information

Client's Name:	Date of Birth:	Gender:
Medicaid ID:	Cell Phone:	Home Phone:
Language:	Address:	

Diagnosis & Medical History

Mental Health Diagnosis:	Outpatient Mental Health Provider:
Medical Diagnosis:	Primary Care Physician:

Hospitalizations in the last 12 months (Please list any information known such as dates, reason for admission and name of facility):

Does the client have significant behavioral, medical or social risk factors which care coordination can assist with? Please select all that apply:

- Probable clinical risk for adverse events
 - Client is enrolled in a Harp Plan
 - Client is engaging in behaviors known to place them at increased risk for requiring hospitalization
 - Client is a high utilizer of emergency, crisis or inpatient services
- lack of or inadequate social/family/housing support
 - Client is currently homeless
 - Client has fewer than 2 people identified as a support or primary support recently placed in a nursing facility
 - client needs assistance applying for/accessing benefits/ social services or unable to access food
 - client is a victim of intimate partner violence
- lack of or inadequate connectivity with healthcare system or behavioral health system
 - not connected to a PCP, psychiatrist, therapist or other specialist to treat a chronic condition
 - unable to navigate the healthcare system or follow treatment recommendations
- non-adherence to treatments or medication(s) or difficulty managing medications
- deficits in activities of daily living such as dressing, eating, budgeting, meal planning and preparation, and travel
- Released from incarceration, hospitalization, or nursing facility within the past 90 days

Reason for Referral/how would the client benefit from care coordination services?

Do any of the following apply to the client:

- Currently assigned to an ACT Team
- Currently assigned to Health Home Care Coordination Services
- Currently under an AOT Order

Referral Source Information

Name of referring worker:	Agency:
Contact Number:	Email:

Referrals can be faxed to: 212-543-0418