

Please list all of the client's medical and psychiatric diagnoses: _____

Does the client have a Primary Care Physician? YES NO

Date of last Primary Care Physician appointment? _____

Psychiatric Outpatient Services- _____

Date of last appointment? _____

Has the client had a history of any of the following?	CHECK ALL THAT APPLY
No Primary Care Practitioner (PCP)	
No Psychiatric Outpatient Department	
No connection to specialty doctor or other practitioner (if applicable)	
No connection to specialty behavioral health care provider-substance abuse/psychiatric (if applicable)	
Poor compliance with outpatient treatment: medical, psychiatric, MICA (does not keep appointments, etc)	
Inappropriate Emergency Room (ER) use* <small>*includes ER visits that could have been prevented should the consumer have sought/accepted ambulatory/outpatient care when the symptoms of the condition first manifested and/or should the consumer have had access to prevention education for the condition</small>	
Repeated recent hospitalization* for preventable conditions either medical or psychiatric <small>*hospitalizations includes those that could have been prevented should the consumer have sought/accepted ambulatory/outpatient care when the symptoms of the condition first manifested and/or should the consumer have had access to prevention education for the condition</small>	
Recent release from incarceration	
Unable to be effectively treated in an appropriately resourced patient centered medical home <small>* please note that in a medical home it is the primary care physician (medical) who coordinates the care.</small>	
Homelessness	

When complete, fax this form to ACMH at 212-543-0418

For any other Questions call ACMH at 212-543-0592 x 301

or contact caremanagement@acmhny.org

Hospitalization Locations- List all hospital names and locations where the client has been treated in the last 12 months:

Psychiatric- _____

Medical- _____

Outpatient Department- _____

Does the client have significant behavioral, medical or social risk factors which can be modified/ameliorated through care management including:

- | | | |
|---|-----|----|
| • Probable clinical risk for adverse event (e.g. death, disability, inpatient or nursing home admission) | YES | NO |
| • Lack of or inadequate social/family/housing support | YES | NO |
| • Lack of or inadequate connectivity with healthcare system | YES | NO |
| • Lack of or inadequate connectivity with behavioral health system | YES | NO |
| • Non-adherence to treatments or medication(s) or difficulty managing medications | YES | NO |
| • Deficits in activities of daily living such as dressing, eating, budgeting, meal planning & preparation, travel | YES | NO |
| • Learning or cognition issues | YES | NO |

If ALL of the answers to the bulleted items above are “NO”, STOP HERE: Client is not eligible for Health Home Services.

Referral source signature

Date

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