ACMH Inc.
Care Management & Housing

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)*:

Please see below for Health Home Criteria. Please select all that apply:

☐ **Probable clinical risk for adverse events (Must select at least 1 below):**

__**Client is enrolled/ eligible for enrollment in a Harp Plan under Medicaid**

__**Client is currently experiencing new or increased mental health symptoms resulting in impaired functioning or placing them at increased risk for harm to self or others***

__**Client is a high utilizer of emergency, crisis or inpatient mental health services (3+ inpatient admissions or 4+ER visits in past 12mnths)**

☐ **lack of or inadequate social/family/housing support**

__**Client is currently homeless or facing eviction in the next 14 days and has no subsequent housing identified**

__**Client's primary support placed in a nursing facility or institutional setting within the past 90 days***

__**client needs assistance applying for/accessing one of the following: SNAP, Medicaid Transportation, SSI, SSDI, HEAP***

__**client is currently experiencing intimate partner violence in the home***

☐ **lack of or inadequate connectivity with healthcare system or behavioral health system (Must select at least 1 below):**

__**not connected to a PCP or has not seen provider in more than 1year***

__ **Diagnosed with a mental health condition and not connected to psychiatrist or has not seen provider in more than 1yr**

__**Diagnosed with a substance use disorder & not connected to substance use treatment provider or has not seen provider in more than 1yr**

☐ **non-adherence to treatments or medication(s) during the past 90 days:**

Provider Name:_____ **Medications:**_____

☐ **Released from incarceration, hospitalization, ER, Detox, or Residential Treatment Setting within the past 90 days**

Facility Name _____ **Date of Discharge:** _____

***Please provide details to support criteria selected above:**

Do any of the following apply to the client:

_ Currently assigned to an ACT Team _ Currently under an AOT Order _ Currently assigned to Health Home Care Management

Referral Source Information

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

Referrals can be faxed to: 212-543-0418