COMMUNITY CARE MANAGEMENT PARTNERS HEALTH HOME

Health Home Referral Form

Send via Encrypted Email: Referrals@ccmphealthhome.org

Section A: Member Demographics

Last Name: | First Name:

DOB: | HARP: Yes ◯ No ◯ | CIN#

Gender: ◯ Male ◯ Female ◯ Other | Preferred Language:

Primary Phone Number: ☐ Home ☐ Cell ☐ Other:

Address:

Type of Residence:

☐ Private Residence (alone or with spouse/partner, parent, child, or other family)
☐ Homeless (street, park, drop-in center, or other undomiciled) ☐ Supportive Housing
☐ Homeless Shelter or Emergency Housing ☐ Other:

Section B: Referral Information

Referral Source:

◯ Family ◯ Self ◯ MCO ◯ Hospital: _____ ◯ Other:

Referring Agency/Program/Facility:

Referring Worker's Name:

Referrer's Phone Number/Email:

Section C: Eligibility

Medicaid Eligibility: ◯ Medicaid FFS ◯ Medicaid Managed Care:

Referrals must have EITHER two or more chronic conditions OR one single qualifying condition.
If member has SMI or HIV, indicate whether the member is Health Home Plus eligible.

◯ Two or more chronic conditions:
Mental Health Condition (non-SMI)

Substance Use Disorder

Asthma
Heart Disease
Diabetes
BMI >25

Other Chronic Conditions:

◯ Single qualifying condition
☐ **HIV / AIDS**

Not HH+ for HIV Eligible to my knowledge

☐ **Serious Mental Illness**

Not HH+ for SMI Eligible to my knowledge

☐ **Sickle Cell Disease**

Additional Comments/Notes:

Updated 2/22/21

Significant Risk**:** Members must be appropriate for Health Home services, by having one or more significant risk factors.

- ☐ Probable risk for adverse events
- ☐ Lack of adequate social/family/housing support
- ☐ Non-adherence to treatment or medications or difficulty managing medications
- ☐ Recent release from incarceration or psychiatric hospitalization
- ☐ Lack of adequate connectivity with healthcare system

Click here for examples of Significant Risk Factors

Additional Comments/Notes:

If referral is from an MCO, are they tagged as High Risk? ☐

If referral is from an MCO, are they tagged as POP? ☐

CCMP Office Use Only

Completed by:	***Date:***
CMA Referred To:	
Date:	***Confirmed By:***