Attachment 2 Revised 8/13/18

NEW YORK STATE OF OPPORTUNITY. Office of Temporary and Disability Assistance | NEW YORK STATE Department of Health

Health Home Eligibility Screening and Referral Form

To enroll in the Health Home (HH) program, applicants must be actively enrolled in Medicaid Fee for Service (FFS) or a Medicaid Managed Care program (or be potentially Medicaid eligible), have a qualifying condition(s), and be able to benefit from HH Services.

Name: _____ Date of Birth: _____ Medicaid CIN #: _____

Eligibility for Health Home: *Please check appropriate boxes*

1. Does the individual have an active and open Medicaid case or is he/she potentially Medicaid eligible?

   ☐ Yes (go to Q.2) ☐ No (**STOP** – Medicaid eligibility is required)

2. ☐ Does the individual have one of the single qualifying chronic conditions listed below?

   ☐ HIV/AIDS

   ☐ Serious Mental Illness (SMI)

   ☐ Yes (go to Q.4) ☐ No (Go to Q.3)

3. ☐ Does the individual have two or more qualifying chronic conditions?

   ☐ Yes- Please list chronic conditions and go to Q.4 ☐ No (**STOP** – one single qualifying condition or two chronic conditions are required)

_____

4. Appropriateness Criteria: *Please check appropriate box/boxes – in addition to the above eligibility criteria, the individual must also meet at least one of the criteria below:*

   ☐ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
   ☐ Has inadequate social/family/housing support, or serious disruptions in family relationships;
   ☐ Has inadequate connectivity with healthcare system;
   ☐ Does not adhere to treatments or has difficulty managing medications;
   ☐ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
   ☐ Has deficits in activities of daily living, learning or cognition issues

If the individual does not meet the criteria outlined above, then a Health Home referral is not appropriate. For assistance regarding this screening and referral form Districts can contact DOH at: 518-473-5569.

Date Referral to Health Home Completed _____Health Home Name _____

Health Home Contact Name and Phone Number _____

Local District Worker Name and Phone Number _____

Attach the signed consent form to this form.