ABBOTT HOUSE – HEALTH HOME REFERRAL AND ELIGIBILITY APPLICATION

BASIC DEMOGRAPHIC

CHILD'S NAME (***LAST, FIRST, MI***) (Include any alias, nicknames or other names the child may be known by):	DATE OF BIRTH:	TODAY'S DATE:

CHILD'S CURRENT ADDRESS:	CITY:	ZIP:	COUNTY OF RESIDENCE:

GENDER: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Not Known	IS CHILD IN FOSTER CARE? ☐ Yes ☐ No ☐ Unknown	LANGUAGE PREFERENCE:

INSURANCE

MEDICAID/CIN #:	MCO PLAN NAME: (If any)	**Please attach copy of Medicaid card if available**

PERMISSION TO REFER: *You must identify that consent to refer has been obtained and who has given consent to refer. Please note that this can be verbal.*

PLEASE INDICATE THE INDIVIDUAL FROM WHOM YOU HAVE OBTAINED CONSENT TO REFER A CHILD TO THE HEALTH HOME PROGRAM:
☐ Parent ☐ Guardian ☐ Legally authorized representative ☐ Individual is 18 years or older ☐ Individual is under 18, but is pregnant, married, or a parent

Date permission obtained:

LEGAL GUARDIAN

MEDICAL CONSENTER'S NAME:	RELATIONSHIP TO CHILD: _____	E-MAIL ADDRESS:

MEDICAL CONSENTER ADDRESS:	CITY:	STATE:	ZIP CODE:	COUNTY OF RESIDENCE:

GUARDIAN'S PHONE NUMBERS:

Home: Cell:

FAMILY/RESIDENTIAL INFORMATION

IS ANY OTHER FAMILY MEMBER CURRENTLY ENROLLED IN A HEALTH HOME?
☐ Yes ☐ No

IF YES, FAMILY MEMBER:	RELATIONSHIP TO CHILD:	HEALTH HOME NAME:	CARE MANAGEMENT AGENCY:

HEALTH HOME ELIGIBILITY CRITERIA *Please attach copy of documentation supporting any of these conditions if available*

ELIGIBILITY TYPE (*only one required):*
Please provide ICD-10 if available

☐ Two or More Chronic Conditions-List Conditions:

1.

2.

☐ Serious Emotional Disturbance (SED)
List Diagnosis: _____

☐ Complex Trauma

APPROPRIATENESS CRITERIA *(Check all that apply)*

☐ At risk for adverse event (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

☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

REFERRAL SOURCE

☐ Hospital ☐ MCO ☐ VFCA ☐ LDSS Rest of State ☐ Community Based Organization ☐ School ☐ Primary Care Physician
☐ Mental Health Provider ☐ Specialist ☐ Preventive Services ☐ Other:

REFERRAL ORGANIZATION:	PERSON MAKING REFERRAL:

CONTACT INFORMATION OF PERSON MAKING REFERRAL:

PHONE: EMAIL: