The Association for Rehabilitative
ACMH
Case Management & Housing

Health Home Referral Assessment

Client Name: _____
Client's Address:_____
Languages Spoken by the client:_____

Person/Agency making referral: _____
Referral source phone/email address: _____

Client is Medicaid eligible? YES NO

Client Medicaid Number- _____

If No, stop here: Client is not eligible for Health Home Services.

Does the client receive ACT services? YES NO

If yes, with which agency? _____

If YES, stop here: Client is not eligible for Health Home Services through ACMH.

Does ACMH act as Representative Payee for the client? YES NO

If YES, stop here: Client is not eligible for Health Home Services through ACMH.

Is the client already linked to a Health Home Care Coordination Program? YES NO

If YES, stop here: Client is not eligible for Health Home Services through ACMH.

Is the client under an active Assisted Outpatient Treatment (AOT) order? YES NO

If YES, stop here: Client is not eligible for Health Home Services through ACMH.

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

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@acmhnyc.org

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* *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	
Repeated recent hospitalization* for preventable conditions either medical or psychiatric *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	
Recent release from incarceration	
Unable to be effectively treated in an appropriately resourced patient centered medical home * please note that in a medical home it is the primary care physician (medical) who coordinates the care.	
Homelessness	

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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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