Your partners in **hope.**

Do you...

Have Medicaid?

Need help with your healthcare?

Need a partner in hope?

It's all free.

Your Care Coordinator can help you and
put you on a path to a better life.

This is what they can do for you.

Coordinate free care services at your home.

Advocate on your behalf so you receive the care you deserve.

Refer you to doctors and specialists for medical and mental health needs.

Help you manage your medications and treatment plans.

Schedule all your necessary appointments.

Find you all financial assistance programs you may qualify for.

Provide resources for finding affordable housing, food, clothing, childcare and transportation.

We're always here.

Call 716-566-4100 or 1-800-466-2040.
Learn more at healthhomewny.com.
Email us at hope@healthhomewny.com.

HEALTH HOME
PARTNERS OF WESTERN NEW YORK

Referral for care coordination services.

Client Name ______________________ Referral Date ___/___/____

Address ______________________ Gender M ☐ F ☐ T ☐

______________________ Social Security Number ___-___-____

DOB ___/___/____ Phone ___-___-____

Primary Language ______________________

Translator Needed Y ☐ N ☐

Referred By ______________________ Referrer Organization ______________________

Referrer Phone/Email ______________________

How did you hear about Health Home Partners? ______________________

Eligibility information for health home services:
Active Medicaid, HIV/AIDS, or SPMI
or two or more chronic health conditions.

Insurance Information

Medicaid Number ______________________

Is the client enrolled with a Managed Care Organization? Y ☐ N ☐ If yes, which MCO? ______________________

Are you currently enrolled in a Health Home? Y ☐ N ☐ If yes, which Health Home? ______________________

Please provide answers to all of the following.
Identify specific diagnosis and provide pertinent information.

NOTE: Documentation in the form of medical records or assessments must be provided to support any diagnosis listed below. If you are unsure of criteria for Health Home services, NYSDOH guidance is available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_home_policy.htm

HIV/AIDS Diagnosis Y ☐ N ☐ ______________________

Serious Mental Illness Diagnosis Y ☐ N ☐ ______________________

Mental Health Diagnosis Y ☐ N ☐ ______________________

Substance Abuse Diagnosis Y ☐ N ☐ ______________________

Please Indicate Any of the Following Asthma ☐ BMI>25 ☐ Diabetes ☐ Heart Disease ☐

Other Chronic Conditions ______________________

Care Coordination Provider Preference

No Preference ☐ Evergreen Health Services ☐ Catholic Health ☐

FACS ☐ Spectrum Human Services ☐ TSI ☐ DePaul ☐

Medical Provider (Identify name, address, phone and specialty)

____

____

____

Care Coordination Needs (Please check all that apply)

Homelessness ☐ Inadequate Housing ☐ Inadequate Nutrition/Food ☐ Financial Needs ☐

Lack of Natural Supports ☐ Deficits in Daily Living Skills ☐ Unaddressed Physical Health Needs ☐

Non-adherence to Treatment ☐ Non-adherence with Medications ☐

Transition from Hospital (Last Six Months) ☐ Repeated ER/Inpatient Use ☐

Lack of or Inadequate Connectivity to Outpatient Health Care ☐ Learning or Cognition Issues ☐

Transition from Incarceration (Last 12 Months) ☐

Probable Risk for Adverse Events (i.e., Death, Disability, Inpatient/Nursing Home Admissions) ☐

Comments/Notes ____

____

____

Scan and email to: hope@healthhomewny.com

Fax to: 716-832-1271

Mail to:
Health Home Partners of WNY
1280 Main Street
P.O. Box 431
Buffalo, NY 14209

For office use only.

Assigned to Outreach/Engagement On ____ /____ /______ Staff ______________________

Assigned to Care Coordination Services On ____ /____ /______ Staff ______________________

Declined No Active Medicaid ☐ Does Not Meet Eligibility Criteria ☐

Already Assigned to Another Health Home ☐ ______________________

Already Enrolled with Another Health Home ☐ ______________________