



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.





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 _____

Risk and Safety Concerns (Please check all that apply)

Suicidal Ideation Homicidal Ideation History of Suicide Attempts

History of Violence/Assault Active Substance Use Unsafe Living Environment

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 _____