GSI ID: _____

ASSOCIATION FOR
MENTAL HEALTH AND WELLNESS

To Advocate. To Educate. To Empower. Together.

Children's Care Management Community Referral

Phone# (631) 471-7242
Fax# (631) 676-6934

Child's Name: Last: _____ **First:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____/_____/_____ **Gender:** ○ **Male** ○ **Female** ○**Other** **Ethnicity: Hispanic/Latino: Yes / No**

SS #: _____ **Medicaid ID#:** _____ **Managed Care ID#:** _____ **Educational Level:** _____

Race: ○**American Indian/Alaskan Indian** ○ **Native Hawaiian / Other Pacific Islander** **Primary Language:** _____
○**Asian** ○ **White**
○**Black or African American** ○**Other** _____

Parent/Guardian: Last: _____ **First:** _____ **Parent/Guardian Med #:** _____

Primary Phone: _____ **Cell Number:** _____ **Primary Language:** _____

Emergency Contact Name: _____ **Number:** _____

Referral Source: _____ Referral Agency Name: _____

Contact Name: _____ Phone/Fax: _____

Back-up Documentation Provided: **Yes/No** Consent Signed Same Day: **Yes/No**

The child must meet the Health Home eligibility requirements below, please answer accordingly.

- Enrolled In Medicaid (at time of referral): **Yes or No, Pending**
- Have one single qualifying condition Serious Emotional Disturbance (SED) **Yes or No**
  ○Bi-Polar Disorder ○Schizophrenia ○Recurrent Major Depression ○Complex Trauma ○Other: _____
- AIDS/HIV: **Yes or No**

OR

- Two or more chronic medical conditions (Ex. Substance Use, Asthma, Diabetes**): Yes or No**

Please check off those conditions below that would verify criteria and include ICD 10 Code if known.

Physical Health Conditions	Mental Health Conditions	Substance Use Disorders
○ Advanced coronary disease ○ Cerebrovascular disease ○ Congestive heart failure ○ Hypertension ○ Peripheral Vascular disease ○ BMI over 25 ○ Chronic renal failure ○ Diabetes ○ Asthma ○ COPD ○ Other:_____	○ Conduct, Impulse Control, or other Disruptive behavior disorders ○ Dementia in conditions classified elsewhere ○ Depressive and/or Psychoses ○ Eating Disorder ○ Major personality disorders ○ Unspecified Non-psychotic disorder ○ Psychiatric disease (except Schizophrenia) ○ Other:_____	○ Chronic Alcohol use ○ Alcohol Liver disease ○ Cocaine Abuse ○ Drug Abuse: Cannabis/NOS/NEC ○ Substance Abuse ○ Opioid Abuse ○ Other:_____

Need a Care Manager to help get care and services: **Yes or No**

In addition to the above eligibility requirements, child must meet Health Home "Appropriateness" Criteria: Circle as many as applies

- ○ At risk for an adverse event (ex., 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 deficit in activities of daily living, learning or cognition issues or
- ○ Is currently eligible because their caregiver is in a Health Home.

Is CPS, Prevention or Foster Care involved with this family? **Yes or No** If yes, please write name and contact information.
Name: _____ Phone #: _____

Please list any additional concerns that would be helpful in providing Health Home services to this child. Please include home and neighborhood safety concerns.

_____

_____

_____

_____

_____

Children's Health Home Care Management is a service delivery model designed to facilitate access to a multidisciplinary array of social services and supports for children with chronic medical and/or behavioral health conditions. As a part of the Hudson River Health Home provider network, our goal at Association for Mental Health and Wellness is to coordinate and facilitate health home services to children throughout Suffolk County.

Name & Title of Person Completing this form: _____ Date: _____

Signature: _____

----------**For Care Management Agency Use Only**----------

MHAW Program Director: _____ Date: _____ Start date: _____

CCM Assigned: _____ Date Assigned_____