



Health Home Care Management

329 N. Salina St. Suite 303
Syracuse, NY 13202

502 Court St., Suite 210
Utica, New York 13502

Phone: 315-883-3355
Fax: 315-434 5100
healthhome@helio.health

Identifying information

Name: _____ DOB: _____ Gender: _____

Address: _____

County of Residence (circle one): Onondaga / Oswego / Madison / Cayuga / Lewis/
Cortland/Oneida/Madison/Herkimer/Lewis County

Phone Number: _____ Other: _____ E-mail: _____

Any language or translation needs? YES NO Explain: _____

Medicaid Managed Care Organization (if applicable): _____

Medicaid CIN #: _____

Currently inpatient at a hospital: YES NO If YES, Expected discharge date & Location: _____

Contact Information for Person Completing Referral:

Organization: _____ Name: _____

Title: _____ Phone: _____ E-Mail: _____

Eligibility

To be eligible, patient must be enrolled in Medicaid & either Category A or B, or patient must have two or more Category C's.

| Check | Category | Criteria | Diagnosis |
|--------------------------|----------|---|-----------|
| <input type="checkbox"/> | A | Serious Mental Illness/ Serious Emotional Disturbance | |
| <input type="checkbox"/> | B | HIV/AIDS | |
| <input type="checkbox"/> | C | Mental Health Conditions | |
| <input type="checkbox"/> | C | Substance Abuse Disorder | |
| <input type="checkbox"/> | C | Asthma | |
| <input type="checkbox"/> | C | Diabetes | |
| <input type="checkbox"/> | C | Heart Disease | |
| <input type="checkbox"/> | C | BMI > 25 | |
| <input type="checkbox"/> | C | Other Chronic Conditions | |

Risk Factors

Check all that apply.

| Check | Criteria | Details |
|--------------------------|--|---------|
| <input type="checkbox"/> | Probable risk for adverse event (death, disability, inpatient or nursing home admission) | |
| <input type="checkbox"/> | Lack of or inadequate connectivity with healthcare system | |
| <input type="checkbox"/> | Non-adherence to treatments or medication(s) or difficulty managing medications | |
| <input type="checkbox"/> | Lack of or inadequate social/family/housing support | |
| <input type="checkbox"/> | Recent release from incarceration | |
| <input type="checkbox"/> | Recent release from psychiatric hospitalization | |
| <input type="checkbox"/> | Deficits in activities of daily living such as dressing, eating, etc. | |
| <input type="checkbox"/> | Learning or cognition issues | |

Health Home Plus Qualifications

Health Home Plus (HH+) is for adults who are enrolled in a Health Home and have a serious mental illness. To be eligible for Health Home Plus, the individual must have one of the following:

| Check | Criteria | Details |
|--------------------------|--|---------|
| <input type="checkbox"/> | Three (3) or more psychiatric inpatient hospitalizations within last year | |
| <input type="checkbox"/> | Four (4) or more psychiatric ED visits within the past year | |
| <input type="checkbox"/> | Three (3) or more medical inpatient hospitalizations within the past year & who have a diagnosis of Schizophrenia or Bipolar | |

Next Steps If Eligible:

- ❖ You can send an e-mail to bburton@helio.health or healthhome@helio.health
 - Or form can be faxed to 315-434 5100
- ❖ Care Manager will follow up with the client within 2 business days after receipt of approval to offer them support through this new program.

Questions or Concerns?

- ❖ Business Hours Phone: 315-883-3355
- ❖ Fax: 315-434 5100

