Abbott House
Health Home Referral and Eligibility Application

Abbott House is accepting referrals from the community for enrollment of eligible children/youth into Health Home Services. Children/Youth must meet all eligibility requirements to be considered for enrollment.

HEALTH HOME CARE MANAGEMENT SERVICES ELIGIBILITY

1. Child/youth currently has active Medicaid; AND
2. Child/youth meets the NYS Department of Health Eligibility Criteria:

    Two or more Chronic Conditions (Substance Use Disorder, Asthma, Developmental Disability, Diabetes);

    OR

    One Single Qualifying Chronic Condition

    1. Serious Emotional Disturbance **OR**
    2. Complex Trauma

3. Child/youth meet the appropriateness criteria such as has significant behavioral, medical or social risk factors which can be addressed through care coordination.

HOW TO MAKE A REFERRAL

1. Complete the attached Referral and Eligibility Application Form, including as much detail as possible to allow us to verify eligibility for Health Home.
2. Attach supporting documentation of diagnosis (if available).
3. Approved children/youth will be assigned to a Care Manager who will conduct outreach and attempt to engage the child/youth in Health Home Care Management Services.
4. Health Home services are voluntary and the Youth and/or Parent/Legal Guardian will be asked to consent during the outreach and engagement process.
5. Send the completed application and consent via secure email or fax, or mail (at 100 North Broadway, Irvington, NY 10533 for services in Westchester & upper Counties or at 1775 Grand Concourse, 7th Floor, Bronx, NY 10453 for services in NYC):

Abbott House
Filomena LoRusso, Director (for services in Westchester & upper Counties)
914-591-7300 x13020
914-650-1241 (secure fax)
HH-LHVReferral@abbotthouse.net
OR
Sheila Colon, Director (for services in NYC)
718-329-4968 x15564
917-398-8504 (secure fax)
HH-NYCReferral@abbotthouse.net

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TREATMENT RECOMMENDATIONS (Check off areas of concern)

BASIC DEMOGRAPHIC

CHILD'S NAME (***LAST, FIRST, MI***) (Include any alias, nicknames or other names the child may be known by):	DATE OF BIRTH:	TODAY'S DATE:

CHILD'S CURRENT ADDRESS*:*	CITY:	ZIP:	COUNTY OF RESIDENCE:

GENDER: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Not Known	IS CHILD IN FOSTER CARE? ☐ Yes ☐ No ☐ Unknown	LANGUAGE PREFERENCE:

INSURANCE

MEDICAID/CIN #:	MCO PLAN NAME: (If any)	**Please attach copy of Medicaid card if available**

PERMISSION TO REFER: *You must identify that consent to refer has been obtained and who has given consent to refer. Please note that this can be verbal.*

PLEASE INDICATE THE INDIVIDUAL FROM WHOM YOU HAVE OBTAINED CONSENT TO REFER A CHILD TO THE HEALTH HOME PROGRAM:
☐ Parent ☐ Guardian ☐ Legally authorized representative ☐ Individual is 18 years or older ☐ Individual is under 18, but is pregnant, married, or a parent

Date permission obtained:

LEGAL GUARDIAN

MEDICAL CONSENTER'S NAME:	RELATIONSHIP TO CHILD:	E-MAIL ADDRESS:	
MEDICAL CONSENTER ADDRESS:	CITY:	STATE:	ZIP CODE:

GUARDIAN'S PHONE NUMBERS: Home: Cell:	COUNTY OF RESIDENCE:

FAMILY/RESIDENTIAL INFORMATION

IS ANY OTHER FAMILY MEMBER CURRENTLY ENROLLED IN A HEALTH HOME?
☐ Yes ☐ No

IF YES, FAMILY MEMBER:	RELATIONSHIP TO CHILD:	HEALTH HOME NAME:	CARE MANAGEMENT AGENCY:

HEALTH HOME ELIGIBILITY CRITERIA *Please attach copy of documentation supporting any of these conditions if available*

ELIGIBILITY TYPE (*only one required):*
Please provide ICD-10 if available

☐ Two or More Chronic Conditions-List Conditions:

1.

2.

☐ Serious Emotional Disturbance (SED)
List Diagnosis: ________

☐ Complex Trauma

APPROPRIATENESS CRITERIA *(Check all that apply)*

☐ At risk for adverse event (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 deficits in activities of daily living, learning or cognition issues
☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

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REFERRAL SOURCE	
☐ Hospital ☐ MCO ☐ VFCA ☐ LDSS Rest of State ☐ Community Based Organization ☐ School ☐ Primary Care Physician ☐ Mental Health Provider ☐ Specialist ☐ Preventive Services ☐ Other:	
REFERRAL ORGANIZATION:	PERSON MAKING REFERRAL:
CONTACT INFORMATION OF PERSON MAKING REFERRAL: PHONE: EMAIL:	

CAREGIVER NEEDS:	CHILD NEEDS:	RISK BEHAVIORS:	BEHAVIORAL HEALTH:	TRAUMA SYMPTOMS:
☐ Physical Health ☐ Mental Health ☐ Substance Abuse ☐ Caregiver Stress ☐ Supervision ☐ Decision-Making ☐ Informal Supports ☐ Knowledge of Condition ☐ Organization	☐ Living Situation ☐ Peer Interactions ☐ Decision-Making ☐ Recreational ☐ Juvenile Justice/Legal ☐ Sleep ☐ School Achievement ☐ School Behavior ☐ School Attendance	☐ Suicide Risk ☐ Self-Injurious Behavior ☐ Other self-harm ☐ Danger to Others ☐ Sexual Inappropriateness ☐ Bullying ☐ Runaway ☐ Eating Disturbance ☐ Problematic Behavior	☐ Psychosis ☐ Attention ☐ Impulsivity ☐ Depression ☐ Anxiety ☐ Oppositional ☐ Anger Control ☐ Emotional Control ☐ Attachment	☐ Psychosis ☐ Re-Experiencing ☐ Hyperarousal ☐ Avoidance ☐ Numbing ☐ Dissociation ☐ Affective/ Physiological Dysregulation

CARE MANAGER GENDER PREFERENCE:	CARE MANAGER LANGUAGE PREFERENCE:
☐ No Preference ☐ Male ☐ Female	☐ No Preference ☐ Preferred Language:

NOTES