Bassett Healthcare Network
Community Health Navigation

Community Referral Form For Medicaid Health Home and Insurance Help

Mary Imogene Bassett Hospital is offering a **FREE** service and accepting referrals to help individuals obtain Health Insurance and to assist Medicaid recipients with obtaining Navigation services from Bassett's Lead Medicaid Health Home and their Community Based Partnering Organizations.

Does the candidate have Active Medicaid Insurance? If not then, please complete the Demographic Information and Referral Contact Information sections located on the attached referral form and fax to 315-867-1341 (Attention Referral Coordinator).

If the candidate does have, Active Medicaid Insurance please complete as much detail on the attached referral form to allow Bassett to verify eligibility into our Medicaid Health Home Program. The eligibility requirements for the Health Home are listed below.

Medicaid Health Home Eligibility

- ✓ Active Medicaid Insurance **and**
- ✓ 2 Chronic Conditions **and** 1 Risk Factor (Listed Below) **OR** HIV **or** Serious Mental Health Condition

Risk Factors -Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission), Lack of or inadequate social/family/housingsupport, Lack of or inadequate connectivity with healthcare system, Non-adherence to treatments or medication(s) or difficulty managing medications,Recent release from incarceration or psychiatric hospitalization and Deficits in activities of daily living such as dressing or eating.

The final step in determining whether to enroll a member in a Health Home is to determine appropriateness for Health Home services. Simply meeting Medicaid eligibility and qualifying conditions is not sufficient to confirm appropriateness for Health Home enrollment. For example, an individual can have two chronic conditions and be managing their own care effectively thereby not requiring health home care management assistance. To qualify for enrollment and ongoing care management services under health home, an individual must be assessed and found to have significant behavioral, medical, or social risk factors *that require the intensive level of Care Management services provided by the Health Home Program*. If you are unsure if your patient qualifies, please complete the referral form and the Health Home Administration team will review and be in touch with the referring individual within 48 to 72 hours.

We can help with the following items – *just to name a few.*

- ✓ Help to obtain a Primary Care Physician as well as change Providers such as Doctors, Dentists and Specialist if needed.
- ✓ Serve as a link to your healthcare providers so that you feel your needs are being met. Helping with Social Determinants of Health (Food, transportation & homelessness)
- ✓ Assist individuals apply for and/or appeal SSI/SSDI and also assisting people with maintaining their benefits
- ✓ Coordinating hospital admission, discharge including outpatient procedures and assisting with services needed after discharge. Help link you to available community resources as well.
- ✓ Help to identify funding sources to assist in any area the candidate is struggling with (to include Medicaid Transportation, Housing Assistance and Financial insecurities)

This Medicaid Health Home program does not cost the candidate anything, is voluntary and will not affect your Medicaid

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MEDICAID HEALTH HOME and INSURANCE REFERRAL FORM version 1.3

Fax Referrals to 315-867-1341 Attn: Referral Coordinator OR Call: 607-547-4887

DEMOGRAPHICS:

CANDIDATE NAME: _____ PHONE # _____ D.O.B _____ GENDER __

STREET ADDRESS _____ CITY _____ STATE ____ ZIP _____

DATE OF REFERRAL: _____ COUNTY _____

REFFERING SOURCE NFORMATION

CONTACT NAME _____

CONTACT PHN # _____

CONTACT EMAIL _____

CONTACT AGENCY _____

WITHIN 48 TO 72 HOURS OF RECEIVING REFERRAL WE WILL DO OUR BEST TO REACH THE REFERRING ENTITY FOR ANY FOLLOW UP QUESTIONS AND PROVIDE UPDATE ON PROGRESS

INSURANCE INFORMATION

MEDICAID/COMMERCIAL ELIGIBILITY INFORMATION:

MEDICAID: ACTIVE ☐ PENDING ☐

MEDICAID CIN # (REQUIRED) _____

NO INSURANCE? CHECK BOX IF NO INSURANCE ☐

DIAGNOSTIC ELIGIBILITY AND ADDITIONAL INFORMATION

CHRONIC CONDITION 1 _____

CHRONIC CONDITION 2 _____

OR

HIV + /AIDS ☐ OR SERIOUS MENTAL HEALTH CONDITION ☐

ADDITIONAL CANDIDATE INFORMATION

INTERPRETER NEEDED **YES** ◯ **NO** ◯

VETERAN **YES** ◯ **NO** ◯

PRIMARY CARE PHYSICIAN **YES** ◯ **NO** ◯

NAME OF PCP _____

DATE OF LAST VISIT WITH PCP _____

OTHER PROVIDERS OR COMMUNITY AGENCIES CANDIDATE IS WORKING WITH:

_____

RISK ELIGIBILITY (CHECK OFF ALL THAT APPLY)

☐ PROBABLE RISK FOR ADVERSE EVENTS (E.G., DEATH, DISABILITY, INPATIENT OR NH ADMISSION)

☐ LACK OF OR INADEQUATE SOCIAL/FAMILY/HOUSING SUPPORT

☐ LACK OF OR INADEQUATE CONNECTIVITY WITH HEALTHCARE SYSTEM

☐ NON-ADHERENCE TO TREATMENTS OR MEDICATION(S) OR DIFFICULTY MANAGING MEDICATIONS

☐ RECENT RELEASE FROM INCARCERATION OR PSYCHIATRIC HOSPITALIZATION

☐ DEFICITS IN ACTIVITIES OF DAILY LIVING SUCH AS DRESSING OR EATING LEARNING OR COGNITION ISSUES

CANDIDATE SAFETY CONCERNS _____

IMMEDIATE NEEDS? _____

I CERTIFY ABOVE INFORMATION IS ACCURATE TO BEST OF MY ABILITY. CANDIDATE SIGNATURE: _____

IF CANDIDATE DID NOT SIGN ARE THEY AWARE OF THE REFERRAL (PLEASE CIRCLE ANSWER) ? **YES** ◯ **NO** ◯