



Referral of Patient to Mount Sinai Health Home Serving Children

Date: _____ Referring Agency: _____

Name of Person Making Referral: _____

Phone Number: _____ EMAIL: _____

Patient Demographics			
Patient Name: _____		Patient Date of Birth: _____	
Patient Medicaid ID: _____		Patient Address : _____	
Medicaid MCO:	Yes	No	_____
MCO Name: _____	Patient Phone Number: _____		
Chronic Condition Eligibility Screening (Check all that apply): <small>Patient must have 2+ chronic conditions, or HIV/AIDS or SED or SMI</small>			
Diabetes	Serious Emotional Disturbance		
Addiction	HIV/AIDS		
Asthma	Complex Trauma-Screening Complete		
BMI over 25	Possible Complex Trauma- Screening/Assessment Needed		
Other	Serious Mental Illness		
Additional Assessment Items			
Is patient in Foster Care? Yes No If Yes, referral must be sent directly to LDSS/NYC VFCA.			
Does the patient have adequate social/family support?	Yes	No	Is patient homeless? Yes No
Does the patient have learning or cognitive issues?	Yes	No	History of non-compliance with medical follow up? Yes No
Has the patient had more than 2 visits to the ED in the last year	Yes	No	Has the patient had more than 2 hospitalizations in the last year? Yes No
If Yes, how many?			
To your knowledge, is patient already receiving any of the following services:			
Targeted Case Management		Early Intervention	Care at Home _____
How will the patient benefit from Care Coordination?			

If CANS-NY assessment has been completed, CANS-NY Acuity Determination:

At a minimum, verbal consent from patient (>18 years old) or parent/guardian (<18 years old) is required to make a referral.

Whenever possible, consent forms should be completed prior to making the referral. Please contact Joanna Jettoo (information below) for copies of consent form or follow link for DOH consent forms:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_forms.htm

Has parent/guardian sign consented forms for HH referral (DOH 5200 and 5201)? Yes No

If yes, consent name and contact information:

Has patient consented to referral AND is either >18 years old, a parent, pregnant, or married (DOH 5055): Yes No

****Please attach copy of completed consent form****

If no written consent has been obtained, has verbal consent been obtained by parent or guardian and documented?: Yes No

Referrals should be sent via secure, encrypted email to Joanna Jettoo, Assistant

HealthHomeReferral01@mountsinai.org or via fax at 212-523-2253