ST. JOSEPH'S Health
A Higher Level of Care

S J H 2 8 6

St. Joseph's Care Coordination Network (SJCCN/Health Home)
Referral Form for Medicaid Patients

Name: _____ **DOB:**_____ **Gender:** _____

Address:_____

County of Residence (circle one): Onondaga / Oswego / Madison / Cayuga / Lewis/ Cortland/Other:_____

Phone: _____ **Cell Phone:**_____ **Other :** _____ **Have a reliable email?:**_____

Any language or translation needs? YES / NO Explain:_____

Medicaid CIN #: _____ **Medicaid Managed Care Org Name (if applicable):**_____

Currently an inpatient at St. Joseph's Hospital? YES/NO If YES, Expected discharge date:_____

Recent history of violence (last 6 months)? YES/NO If YES, did it result in an arrest? YES/NO

Referring unit or entity (example: SJ Family Medicine Center)_____

Referred by (your name and contact number): _____ **Patient interested?**____YES/NO

Preferred Care Management Agency:_____

ELIGIBILITY CHECKLIST (Check all that apply – Must meet two or more to be eligible)

Patient Has Two or More Condition from this Column:

____Heart Disease/CHF

____COPD/Asthma

____Diabetes

____BMI > 25

____Substance Abuse Disorder

____Mental Health Condition

____Other Chronic Condition

____ Significant Risk for Developing another Chronic Condition

And/Or One of the Following Conditions:
(Single Qualifiers)

____HIV/AIDS

____SPMI

And One or More from this Column:

____Probable risk for adverse event (death, disability, inpatient or nursing home admission)

____Lack of/inadequate connectivity w/healthcare system

____Lack of/inadequate housing/social/family support

____History of inability to comply with or manage care plans/medication(s)/treatment(s)

____Recent (past year) release from incarceration

____Recent (past year) release from psychiatric hospitalization

____Education goals

If Eligible: FAX THIS FORM TO 315-703-2466

Explain that a St. Joseph's Care Coordination Network Outreach Specialist will follow up with the client within 3-5 business days to offer them support through this new program

Questions or want to connect a patient directly to a care manager? 1-855-850-5789

Downstream Providers may use this form to notify SJCCN of eligible clients they intend to outreach and/or engage.

SJCCN will verify the Medicaid and availability for services through the DOH Health Commerce Portal upon receipt.

SJCCN will notify the Downstream Provider of the client's eligibility status and update the DOH tracking file to represent the client's assignment to the Downstream Provider submitting the form.

SJCCN Patient Access Representatives will register the clients in the EPIC electronic medical record, if the patient is interested.

Downstream Providers will forward the following documents to be incorporated into the EPIC record:

- Consents
- FACT GP
- Care Plan