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Hudson Valley Care COALITION

Through our care management network, the **Hudson Valley Care Coalition (HVCC) Health Home program** connects eligible Medicaid members to FREE assistance managing their medical and behavioral health needs, appointments, and social services, like food and housing support. Health Home care management is designed for individuals with two or more chronic health conditions, serious mental illness, or other complex needs and risk factors. By completing the referral form below, you are taking the first step to help an individual access personalized, whole-person coordinated care that promotes stability, reduces unnecessary hospital visits, and improves long-term health outcomes.

TO QUALIFY FOR THE HUDSON VALLEY CARE COALITION, AN INDIVIDUAL MUST MEET THE FOLLOWING CRITERIA:

– Have Medicaid (active or eligible with pending application)

– Have 1 or more of the following:

- 2 or more chronic medical conditions, such as mental health condition,
- substance use disorder, asthma, diabetes, heart disease, BMI over 25,
- other chronic conditions.
- a Serious Mental Illness diagnosis
- HIV/AIDS
- Sickle Cell Disease

– Be appropriate for health home services:

- Probable risk for adverse events (e.g. death, disability, inpatient or nursing home admission)
- Lack of or inadequate social/family/ housing support
- Lack of or inadequate connectivity with healthcare system (e.g. no PCP, frequent ED visits or hospitalizations)
- 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

For more information, please contact HVCC at 1-800-768-5080.
For more information about Children Health Home Services call 1-888-980-8410, Option #4.

To make a referral to the HVCC, please fill out the information below about the individual you are referring:

Patient Name: _____ Patient Phone Number: _____

Date of Birth: _____ Gender: ◉ Male ○ Female Medicaid ID Number: _____

Patient Address: _____

City _____ State _____ Zip _____

Was the patient informed of the Health Home program? ☐ Yes

Were you able to provide Health Home information for the patient to take home? ◉ Yes ○ No

Did the patient provide his/her verbal consent to make the referral to the Health Home? ☐ Yes

Name of person making referral: _____ Referring Phone Number: _____

Provider organization: _____

When complete, please send form via SECURE EMAIL to Annecy Cruz at acruz@hvcare.net.
If you do not have access to secure email, please fax the form to 914-488-6635.