Jemcare

Email: intake@jemcare.org
Phone: (718) 506-0721
Fax: (718) 421-9157

Children's Health Home Referral Form

INSTRUCTIONS: This form must be completed in its entirety to allow JEMCare to verify eligibility for Health Home Care Management services. Please attach any clinical documentation to support eligibility. Completed Application must be submitted directly to JEMCare via secure e-mail at INTAKE@JEMCARE.ORG.

Identifying Information		
Last Name:	First Name:	
Date of Birth (mm/dd/yyyy):	Gender: ☐Male ☐Female	
Medicaid ID:	MCO PLAN (If any):	
Home Phone:	Cell Phone (if applicable):	Preferred Language:
Emergency Contact:	Email:	
Current Address:		

Permission to Refer (Must identify if consent to refer has been obtained. Permission to make this referral must be obtained from the parent/guardian/legally authorized representative for children up until the age of 18. For children/youth ages 18-21, or that are married, a parent, or pregnant may provide consent on their own behalf. Please note that this can be a verbal consent.

Date Permission to Refer was Obtained:

Indicate the Individual from Whom Consent to Refer This Member to the Health Home Program was Obtained:

☐Parent
☐Guardian
☐Legally authorized representative
☐Member/ self/ individual if 18 years or older
☐Member/ self/ individual under 18, but is a parent, pregnant, or married

Parent/Legal Guardian/ Legally Authorized Representative [I.E. Medical Consenter] Information	
Name:	
Address:	
Relationship to Member:	Phone:
Is Member in Foster Care? ☐Yes ☐No ☐Unknown	Is Member's Parent/Guardian Currently Enrolled in a Health Home? ☐Yes ☐No ☐Unknown

Referral Source Information

Name of Referral Organization:

Type of Organization:

☐Hospital ☐PCP ☐Specialist ☐Mental Health Provider
☐MCP ☐School ☐VFCA ☐LDSS
☐SPOA ☐LGU ☐Preventive Services
☐Community Based Organization ☐Other Referral Source (Specify):

Name of Person Making Referral:

Contact Information of Person Making Referral:

Phone: Email:

Jemcare

Health Home Eligibility Criteria (Member must have any two or more chronic condition or one of the single qualifying conditions. If ICD-10 code(s) or proof of eligibility/ documentation to support any of these conditions is available, please attach)

Eligibility Type/ Diagnosis Criteria

Two or More Chronic Conditions (Specify):	**Single Qualifying Condition**
☐Asthma ☐Autism ☐ADHD ☐Obesity Other (Specify):	☐Serious Emotional Disturbance (SED) (Specify): ☐HIV/AIDS ☐Complex Trauma ☐Sickle Cell Anemia

Appropriateness Criteria (Member must also meet any of the following risk factors to qualify for health home services.)

☐Experiencing an adverse event (disability/inpatient/emergency department/psychiatric hospital/detox/ skilled nursing/crisis stabilization/mandated preventive services/out of home placement/deceased guardian) in the last 6 months

☐Difficulty navigating system due to member's (or guardian) physical or behavioral health condition such as activities of daily living, learning or cognition issues, transportation, scheduling medical appointment

☐Does not have specialist to treat physical or behavioral condition or has not seen a provider (e.g., PCP, BH, etc.) in the last year

☐Diagnosed with serious physical or behavioral health condition or received initial Disability Determination (SSI or DOH Disability Certificate/letter) within the last 6 months

☐Not adherent to or having difficulty managing treatment or certain medications

☐Needs assistance applying for/accessing benefits such as OPWDD, Childcare Support, SNAP, WIC, SSI, Cash Assistance, Housing Support. etc.

☐Unable to access food due to financial limitations, inability to shop, dietary restrictions, etc.

☐Currently homeless or has no stable living arrangement

☐Currently impacted by violence at home or by intimate partner

☐Released from incarceration/detention center within the last 6 months

☐Recent change in guardianship/caregiver or caregiver/guardian currently enrolled in HH

Additional Information/ History: