MHACG
MHA of Columbia-Greene

Care Coordination Program
Service Referral Form

The Care Coordination program by the New York State Department of Health is to facilitate access to a multi-disciplinary array of services and supports for Medicaid recipients with chronic medical and/or behavioral health conditions. The goal fo the program is to assure that members receive appropriate access to medical, behavioral and social services in an integrated manner.

A Care Coordinator, whose primary role is to oversee the coordination of a member's care and to focus on health promotion, is assigned to each individual.

Eligibility: Applicants must have Medicaid coverage in order to be enrolled in the program AND meet one of the following diagnostic criteria:

- **One serious Mental Illness (SMI); and/or,**
- **HIV/AIDS and the risk of developing another chronic condition; and/or,**
- **Two chronic conditions: mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, other chronic conditions.**

For questions or assistance, please contact Jacklyn P. at 518.751.0039 or Samantha R. at 518.265.4613

APPLICANT CLIENT INFORMATION

Date:

Last Name: First Name: DOB:

Street Address: City: State: Zip:

Mailing Address (if different from above):

Primary Phone: Phone Type: ○ Home ○ Cell ○ Work Gender: ○ Male ○ Female

Secondary Phone: *(optional)* Phone Type: ○ Home ○ Cell ○ Work

Email Address: Preferred method of contact: ○ Phone Call ○ Email ○ Text

Medicaid CIN: SSN (if CIN unknown):

EMERGENCY CONTACT INFORMATION

Full Name: Contact Phone Number: Relationship:

REASON(S) FOR REFERRAL *(select all that apply)*

- ☐ No primary care provider or specialty doctor or other practitioner.
- ☐ Inpatient stays for Substance abuse treatment within previous 6-12 months.
- ☐ Difficulty with compliance (does not keep appointments, etc.)
- ☐ Recent release from incarceration within 6-12 months.
- ☐ Repeated recent hospitalizations for preventable conditions (medical or psychiatric) within past year.
- ☐ Cannot be effectively treated in an appropriately resourced patient centered medical home.
- ☐ Inappropriate Emergency Department use.
- ☐ Homelessness.

WHAT ASSISTANCE CAN BE PROVIDED *(select all that apply)*

- ☐ SPOA/Housing/Homelessness
- ☐ Food Stamps (SNAP) or HEAP
- ☐ Substance Abuse Treatment
- ☐ Managing Prescriptions
- ☐ Locating a doctor or specialist
- ☐ Employment Services / Unemployment
- ☐ Help with benefits / Medicaid / SSI / SSDI / Spend Down
- ☐ Mental Health Services / Scheduling / Clinical Services
- ☐ Referral to Personal Recovery Oriented Services (PROS)
- ☐ Education Services / High School Equivalency (GED)

Please include any additional relevant information:

REFERRAL INFORMATION

Referral Provider/Agency:

Contact Name:

Contact Email:

Contact Phone:

Referring Provider Signature

Applicant Signature

Please email completed forms to CareCoordination@mhacg.org or fax to 518.943.4500

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