



HHUNY
HEALTH HOMES OF UPSTATE NEW YORK
Empowering you. Expanding possibilities.

Comprehensive Assessment Addendums

Member Name _____

Member NSID or CIN _____

Care Management Agency _____

Completed By _____

Date Started _____

Date Completed _____

Addendum C: Hospitalizations

Reason for Admission _____

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

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