

# HEALTH HOME DISCHARGE

Member ID Number: \_\_\_\_\_



Dear \_\_\_\_\_,

As a Venture Forthe Health Home client, your health and wellbeing always come first.

At this time, it has been decided that you will be dis-enrolled with Venture Forthe's Health Home Program due to the following:

- Successful Graduation from Health Home Program
- Partial Completion of Health Home Program
- Member Dis-Enrolled
- Inability to Contact
- Member Dis-Satisfied with Health Home Services
- Medicaid Inactive
- No longer meets eligibility criteria for Health Home Program
- Closed due to behavior
- Multiple Missed Appointments
- Refusal of Services
- Other: \_\_\_\_\_

This is effective: \_\_\_\_/\_\_\_\_/\_\_\_\_ .

Attached you will find a Safety Plan with information that you are able to utilize in the event of an emergency. If you wish to be re-enrolled in the Health Home program, please follow the steps outlined on the Notice of Determination included in this packet to appeal the decision.

Venture Forthe wishes you well with your future endeavors, and hope that you reach out with any questions or concerns that you may have.

Sincerely,

\_\_\_\_\_, Care Manager

# HEALTH HOME DISCHARGE

Member ID Number: \_\_\_\_\_

DEMOGRAPHIC AND ADMINISTRATIVE DATA
Member Name: _____
DOB: _____
Enrollment Date: _____
Discharge Date: _____
Care Manager: _____
Care Manager Supervisor: _____
Health Home: _____
DISCHARGE DIAGNOSES
Discharge Reason/Outcome of Program Involvement (check all that apply)
<input type="checkbox"/> Successful Graduation from Health Home Program
<input type="checkbox"/> Partial Completion of Health Home Program
<input type="checkbox"/> Member Dis-Enrolled
<input type="checkbox"/> Inability to Contact
<input type="checkbox"/> Member Dis-Satisfied with Health Home Services
<input type="checkbox"/> Medicaid Inactive
<input type="checkbox"/> No longer meets eligibility criteria for Health Home Program
<input type="checkbox"/> Closed due to behavior
<input type="checkbox"/> Multiple Missed Appointments
<input type="checkbox"/> Refusal of Services
<input type="checkbox"/> Other: _____ _____
Care Manager Recommendations
<input type="checkbox"/> Continue Medications
<input type="checkbox"/> Follow Up with Provider: _____
<input type="checkbox"/> Reactivate Medicaid
<input type="checkbox"/> Link with Services: _____
<input type="checkbox"/> Enroll with MCO: _____
<input type="checkbox"/> Other: _____ _____
RELINKAGE INSTRUCTIONS (IF APPLICABLE)
Health Home: _____
Care Management Agency: _____
Phone: _____ E-Mail: _____
<input type="checkbox"/> MEMBER IS NOT ELIGIBLE FOR HEALTH HOME SERVICES AT THIS TIME
<input type="checkbox"/> MEMBER IS NOT ELIGIBLE TO RE-ENROLL WITH PREVIOUS CARE MANGEMENT AGENCY, BUT CAN ENROLL WITH ANOTHER AGENCY OF THEIR CHOICE

# HEALTH HOME DISCHARGE

Member ID Number: \_\_\_\_\_

## EMERGENCY CONTACTS

### **Contact 1:**

Individual : \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

### **Contact 2:**

Individual : \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_

NYPD  
911

NATIONAL DOMESTIC VOILENCE HOTLINE  
800-799-SAFE (7233)

SAFE HORIZON DOMESTIC VOILENCE HOTLINE  
800-621-HOPE (4673)

SUICIDE PREVENTION HOTLINE:  
1-800-273-8255

CAMBA VICTIM SERVICES  
(718) 282-5575

CRISIS SERVICES  
(716) 834-3131

ADDICTION OPEN ACCESS HOTLINE  
(716) 831-7007

## EMERGENCY PREPAREDNESS

IN THE EVENT OF AN EMERGENCY, PREPARE WITH THE FOLLOWING ITEMS:

- Identification (All Individuals)
- Order of Protection
- Social Security Card (All Individuals)
- Medicaid Card
- Passport/Green Card (All Individuals)
- Bank Card/Credit Card/Cash/Checkbook
- Medical Documentation (All Individuals)
- Legal Documents
- Medication (All Individuals)
- Clothing
- Baby Items (Food, Clothing, Diapers, Medication)

## CARE MANAGER/CARE MANAGER SUPERVISOR NOTES