**To Our Fellow Service Providers**

We know how busy you are—and how complex your clients’ needs can be.

**What if you had another team member to help coordinate and manage care your clients’ healthcare needs?**

* That’s what we do. For Free. Please contact us if you have any questions about the eligibility and referral process for ACMH’s Care Management Services.

**Eligibility for ACMH Care Management Services (CMS) through the New York State Health Home Program**

* To be eligible for CMS, the applicant must:
* have an active Medicaid case; AND
* be diagnosed with:
	+ Two Chronic Conditions#\*: - [Eligibility Criteria for Health Home Services: Chronic Conditions](http://0201.nccdn.net/4_2/000/000/023/130/09-23-2014_eligibility_criteria_hh_services-downloaded-from-NYS-DOH-Webs....pdf)
* Serious Mental Illness (SMI) or HIV/AIDS

**In addition, the applicant must exhibit at least ONE of the criteria below:**

Applicant has significant behavioral, medical, or social risks factors (needs) which can be ameliorated through Care Coordination services. Examples include:

* Lack of or inadequate connectivity to health care system
* Non-adherence to treatment or medication or difficulty managing medications
* Recent release from incarceration or psych hospitalization
* Lack of or inadequate social, family, or housing support
* Learning or cognitive issues
* Deficits in ADLs
* Probable risk for adverse event

Applicant has a history of poor connectivity to care, including but not limited to:

* No Primary Care (PCP)
* Homelessness
* No connection to specialty MDs
* Inappropriate ER use
* Does not keep appointments
* Repeated recent hospitalizations for preventable conditions
* Recent release form incarceration
* Cannot be effectively treated in a patient-centered medical home