# Enrollment Form

The Primary Care Health Home Enrollment Form must be completed in full. Please complete the form, save a copy, and submit in an email to PCHH@dss.mo.gov using the state Proofpoint encryption system. Indicate "PCHH ENROLLMENT" and the number of forms attached (maximum of 15) in the **subject line** of the email.

PART 1

**NOTE**: **Please verify that the patient is currently eligible for Medicaid (eMOMED) and is not currently enrolled in a health home or PACE(Cyber Access).**

**Patient must have at least one of these criteria to enroll:**

- Medicaid spend exceeds 1 year of PMPM cost in last 12 months (approximately $775)
  OR
- at least one ED visit or hospitalization in the past 12 months

Health Home: _____ HH Provider #: _____

**(Must contain 9 digits)**

PART 2

Date: _____ MO HealthNet ID/DCN #: _____ Date of Birth: _____

**(Must contain 8 digits)**

Participant Name: _____ (Last) _____ (First) _____ (MI)

PART 3

**ENROLLMENT CONDITIONS - Check ALL diagnoses that apply. Example: If Diabetes and Cardiovascular Disease apply, check both, regardless of stand-alone condition.**

**Must have a minimum of 2 Chronic Conditions or 1 Stand-Alone Diagnosis**

**Chronic Conditions** - Check all that apply

- ☐ Asthma
- ☐ Cardiovascular Disease
- ☐ COPD
- ☐ Developmental Disability
- ☐ Overweight (BMI 25-29 [Adult] or 85th to 94th percentile [Peds])
- ☐ Tobacco Use

**Behavioral Health Condition** - Only **one** may count towards your minimum of 2 chronic conditions, but check all that apply

- ☐ Anxiety
- ☐ Depression
- ☐ Substance Use Disorder

**Stand-Alone Conditions - Check all that apply**

- ☐ Asthma (pediatric)
- ☐ Obesity (BMI ≥ 30 [Adult] or 95$^{th}$ percentile [Peds])
- ☐ Diabetes
- ☐ Chronic Pain

PART 4

**MOHEALTHNET USE ONLY:**

☐ Approved ☐ Denied

Date Form Received: _____ Effective Date of Enrollment: _____

NOTES: _____

Request Processed by: _____