Health Homes Program

About the Health Homes Program

The Health Homes Program provides extra services at no cost to people covered by Medi-Cal who have certain chronic conditions. These services help them get the care they need to stay healthy.

Who Can Join the Health Homes Program?

To receive Health Homes Program services people must:

1. Have Medi-Cal coverage and be enrolled in a Medi-Cal plan
2. Have certain chronic health conditions (such as asthma, diabetes, kidney or liver disease, heart failure, etc.)
3. Have been in the hospital, had visits to the emergency department, or be chronically homeless

Medi-Cal plans will contact their members who qualify for the program. People can also call their Medi-Cal plan to find out if they qualify, or they can ask their doctor or clinic about the program.

How Can the Health Homes Program Help People?

People who join the Health Homes Program are given a care team of health care and social service providers that help them:

- Find doctors and get appointments
- Coordinate the care they receive from different providers
- Understand their prescription drugs
- Get follow-up services after they leave the hospital
- Connect to community and social services, such as food and housing

Joining the Health Homes Program will not take away or change any Medi-Cal benefits.

For More Information:

Visit the DHCS Health Homes webpage at bit.ly/HealthHomes or call the local Medi-Cal plan. To find the phone number, go to www.dhcs.ca.gov and search for "health care directory."

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What Services Does the Health Homes Program Offer?

People are given a care team – including a care coordinator – that works together to help them get the health care and community services they need.

The care team may include the person's current and new health care providers, such as doctors, specialists, and pharmacists. It may also include case managers or others from community organizations serving the patient.

Health Homes Program services can help:

1. **Develop a Plan for Patients:** People will work with their care team to create a "Health Action Plan" to help them meet their health care goals and stay healthy.

2. **Keep Providers Coordinated and Up to Date:** The care coordinator and the care team will work together to keep all providers up-to-date about the patient's health care needs and the services they receive.

3. **Give Patients Information to Stay Healthy:** People and their family members can learn about the best ways to manage their health conditions.

4. **Move Patients from One Care Setting to Another:** The care team will help people move safely and easily between different care settings, such as entering or leaving a hospital or nursing facility, and returning to their own home.

5. **Strengthen the Patient's Support Systems:** People can choose to include family or friends on their care team so they have up-to-date information on the patient's conditions and ways to help and support them.

6. **Connect Patients to Community Services:** The care team can help people find and apply for needed community and social services, such as food, temporary and permanent housing, child care, disability services, and others.

How Do People Sign Up for the Health Homes Program?

If people would like these new services, they must sign up for the program. The program is voluntary, and people can stop the services at any time.

- Most people who qualify will receive a letter from their Medi-Cal plan telling them they qualify and how to sign up.
- Providers can also refer their patients. The provider would need to contact the patient's Medi-Cal plan to see if they qualify.
- People can call their Medi-Cal plan to see if they qualify and to sign up.

For more information on how to sign up, **please call Health Care Options at 1-800-430-4263.**