The Health Home program provides:

- Comprehensive care management.
- Care coordination and health promotion.
- Transition planning.
- Individual and family support.
- Referral to relevant community and social support services.

Health Home

It's care coordination to improve your health.

Care coordination for better health

Health Home Program

... for a better life!

Use Health Home services to coordinate your health and social services and *improve your life*.

HCA 22-860 EN (7/16) English

What is the impact on you?

Health Home services support you in your health journey. Your participation is voluntary. It does not impact your eligibility for other services or your complaint and appeal rights.

Call 1-800-562-3022 for more information

What is a Health Home?

A Health Home is not a place. It is a set of services to support you if you have serious chronic conditions and more than one medical or social service need.

Health Home services can make things go more smoothly between your medical and social service support. This may help reduce visits to hospitals and emergency rooms and support your health, overall well-being, and self-care.

How do the services work?

- Health Home services are managed through a care coordination agency.
- The care coordinator meets with you to assist you in developing your health action plan.
- The care coordinator stays in touch with you and the agencies that support you to keep things moving along.
- If you go in and out of the hospital, the care coordinator will assist in planning your transition.
- If you have trouble getting the support you need, the care coordinator can assist you in working with providers and mental health or chemical dependency agencies to get care.

Are these services for you?

You may be eligible if you:

- Are a Medicaid client;
- Have a serious chronic condition; and
- Are at risk for a second one.

How much does this cost?

Nothing — it's a free service.

What will this do for you?

- Provide support to help you manage complicated medical and social needs.
- Provide help to find and get long-term services in your community.

How do you start?

- When a care coordinator contacts you, tell them you want to participate.
- Then, work with the care coordinator, make a Health Action Plan, and get started!

Will this change the people you work with now?

You can continue to work with the same people—the program will just add a person to help you develop and follow up on your Health Action Plan. You can continue to work with:

- Your paid caregivers.
- Others you work with (for example, doctors, nurses, physical therapists, mental health counselors, and chemical dependency staff).
- Your Area Agency on Aging and other case managers.

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives