CARE CENTRAL REFERRAL FORM

DATE_____

Referral Criteria

- ○ **Two chronic medical conditions (Specify)** _____

NOTE: If an individual has HIV, they do not have to be determined to be at risk of another condition to be eligible for Health Home services.

AND/OR

- ○ **One serious persistent mental health condition (Specify)**_____

AND

- ○ **Medicaid, or Medicaid eligible and in process of applying or willing to apply**

Reason for Referral ***(Check any/all that apply, provide comment, and attach documents as appropriate)***

- ○ **Already consented to Care Central**
- ○ **Lack of or inadequate social/family/housing support**
- ○ **Lack of or inadequate connectivity with healthcare system**
- ○ **Non-adherence to treatments or medication(s) or difficulty managing medications**
- ○ **Repeated recent hospitalization or Emergency Department use**

Community Services ordered or already in place ***(Check all that apply, specify as appropriate)***

- ○ **Visiting Nurse Service**
- ○ **Long Term Care program**
- ○ **Outpatient Mental Health or Substance Abuse Treatment**
- ○ **Primary Care Provider** ***(identify)*** _____
- ○ **Any other case management or service coordination in place**

Name
Date of Birth **Gender:** ☐ **Female** ☐ **Male**
Insurance ID: **Medicaid/CIN**
Address
Phone Number
County: (circle one) Schenectady Southern Saratoga

Referral Source Information

Name
Agency **Phone Number**
Email

Care Central will contact the referral source by phone or email

Care Central Phone Number: 1-855-204-0888 **Care Central Fax Number: 518-347-5546**