CARE CENTRAL Jail/Prison Release REFERRAL FORM

DATE_____

Referral Criteria

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

OR

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

AND

- ○ **Medicaid eligible and willing to apply**

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

- ○ **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**

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 (if available)** **Incarceration date** **Release date**
Do you have housing upon release?
Phone Number
County of expected residence:

Jail/Prison contact information

Name
Facility **Phone Number**
Email

Care Central will contact the referral source by phone or email

Care Central Phone Number: 1-855-204-0888 or 518-612-8610 **Fax Number:** 518-347-5546

CARE CENTRAL Jail/Prison Release REFERRAL FORM

Release Status

Parole/Probation	**Yes____**	**No___**
Max Out (no Parole)	**Yes____**	**No___**
Other (specify):_____	**Yes____**	**No___**

Contact information Parole/Probation Officer

Name

Phone Number

Email

Reason for incarceration

History of violence (please specify)

Did inmate have previous MH/SUD providers? (Please list)

Are they taking medications currently? (Please list)

Care Central Phone Number: 1-855-204-0888 or 518-612-8610 **Fax Number:** 518-347-5546