THE INSTITUTE FOR FAMILY HEALTH

HEALTH HOME

Phone: (877) 207-3387
Email: Memartinez@institute2000.org
Fax: 845-255-3089 Attn: Melissa Martinez

Referral of Patients to the Ulster County Health Home

Date:_____ Provider:_____

Name of Person Making Referral:_____

Phone Number:_____

Patient Name:_____ Patient Date of Birth:_____

Medicaid ID#:_____

Medicaid MCO: ___Yes ___NO MCO Name:_____

Address & Phone Number:

_____
_____
_____

Consent to refer provided by:

___ Parent ___ Guardian ___ Legal Authorized Representative
___Child/adolescents over 18, a parent, pregnant/married

Referral Reason:

__Two or more Chronic Conditions
__Mental Illness
__Serious Emotional Disturbance
__Complex Trauma
__ HIV/AIDS
__Addiction
__Other

List Chronic Conditions:

_____
_____
_____

How will the patient benefit from Care Coordination:

_____
_____
_____

HEALTH HOME

(877) 207-3387

Consent For Health Home Referral

Date:_____

To Health Home:

I _____ parent/guardian of _____ give consent for a Health Home referral to be placed.

I have received Health Home information and request a Health Home care manager contact me at telephone number _____.

Parent/guardian signature:_____

THE INSTITUTE FOR FAMILY HEALTH