CARE COORDINATION

REFERRAL FORM

Helping you achieve Optimal Wellness

HOW DO I MAKE A REFERRAL?

Thank you for choosing Community Access Care Coordination! Please complete both pages of this form and email a scanned copy to CareCoordination@communityaccess.org, and a member of our team will get back to you about next steps. We encourage sending additional documents to support eligibility whenever possible.

WHO'S ELIGIBLE FOR CA CARE COORDINATION?

All applicants must answer yes the each question below:

Do you have active Medicaid? ◯ Yes ◯ No
Are you 18 years or older? ◯ Yes ◯ No

Are you a resident of NYC? ◯ Yes ◯ No

Have you been diagnosed with one or more of the following? Check all that apply

- ☐ Mental Illness (*required*)
- ☐ 2+ chronic medical conditions
- ☐ HIV/AIDS

The following services CANNOT be combined with Care Coordination:

X ACT X AOT X OPWDD

If one or more of the following were true in the last 12 months, you may qualify for more intensive services (Health Home Plus):

- ☐ Experienced shelter or street homelessness
- ☐ Had 4+ visits to the psychiatric ER or CPEP
- ☐ Had 3+ psychiatric inpatient hospital stays
- ☐ Had 3+ medical inpatient hospital stays AND bipolar disorder or schizophrenia diagnosis
- ☐ Discharged from a state psychiatric hospital
- ☐ Stepped down from ACT or AOT services
- ☐ Currently on the ACT waiting list
- ☐ Released from jail or prison

QUESTIONS?

Call 212-780-1400, ext. 7791 or ext. 7735
Email CareCoordination@communityaccess.org
Online www.communityaccess.org

APPLICANT INFORMATION

Demographic Details

Name: _____

Pronouns: _____

Date of Birth: _____

Social Security # (optional): _____

Medicaid number: _____

Managed Care Plan: _____

HARP enrolled: ◯ Yes ◯ No ◯ Unknown

Diagnosis (checked off above): _____

_____

Contact Information

Address: _____

_____

Phone number(s): _____

_____

Email address: _____

Preferred contact method(s):

☐ In-person ☐ Phone ☐ Email ☐ Video

Something else _____

_____

REFERRAL SOURCE INFORMATION

If different from applicant

Name and organization (if applicable): _____

Relationship to applicant: _____

Phone number & email address: _____

REASON FOR REFERRAL

Please feel free to attach additional pages and/or supplemental documents to support your referral

Applicant signature _____ **Date** _____

Referral source signature _____ **Date** _____