HVCS Community & Health Care Coordination

Referral Form

Fill out as much information as possible. It is not necessary to complete the form in full to make a referral.

Referral Source: _____ _____
(Office/Practice/Doctor/Group Name) **(Telephone #)**

First Name:* _____ **Last Name:*** _____

Phone:* (____) _____-_____ **Medicaid #*:**_____
(if known)

**Required*

Address: _____ Apt, Bldg., C/O, etc.: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security#: _____

Gender: (Please Check Appropriate Status)

☐ Female ☐ Male
☐ Transgender (Identifies as Female) ☐ Transgender (Identifies as Male)
☐ Intersex/hermaphrodite

Primary language spoken _____

Chronic Condition Eligibility Criteria	
☐ HIV/AIDS	☐ Diabetes or other Metabolic Disease
☐ Chronic Mental Illness	☐ Asthma or COPD
☐ High Blood Pressure/ Hypertension	☐ Other Respiratory Diseases
☐ Other Cardiovascular Diseases	☐ Alcohol/Substance Abuse Disorder
☐ Obesity	☐ Cancer
☐ Mental Health Condition (MH)	☐ Alzheimer's Disease or Dementing Disease
☐ Other:_____	

There are more than 200 qualifying health conditions: for a full list please visit www.hudsonvalleycs.org/healthhome

Does the individual need assistance obtaining:

Nutritious food	☐ *Yes*	☐ *No*
Housing	☐ *Yes*	☐ *No*
Entitlements (SSI/SSD benefits, food stamps, DSS, etc.)	☐ *Yes*	☐ *No*
Transportation	☐ *Yes*	☐ *No*

Please fax completed form to (914) 345-3106 or scan to hhcare@hudsonvalleycs.org

If you prefer to make a referral via phone, please call 844-850-0002.

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