# Health Home Referral Form

CORNERSTONE FAMILY HEALTHCARE

Date: ___________

*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 #*:______________________________

**Required*

Address: ________________________________ Apt, Bldg., C/O, etc.: __________________

City: ______________________________ State: __________ Zip: ___________

Date of Birth: ____________________ Social Security#: ___________________

Client's Gender: ________________________

Primary language spoken: ________________________

| Current medical conditions: | |
|---|---|
| ☐ 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 Use Disorder |
| ☐ Obesity | ☐ Cancer |
| ☐ Mental Health Condition (MH) | ☐ Alzheimer's Disease |
| ☐ Other: | |

________________________________________________________________

There are more than 200 qualifying health conditions: for a full list please visit:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes

**Does the individual need assistance with:**

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

**Please fax completed form to (845) 306-2433 or scan to hhcare@cornerstonefh.org**
**If you prefer to refer via phone, please call (845) 306-2433.**