CARE MANAGEMENT PARTNERS OF ULSTER COUNTY
A New York State Health Home Program

Refer a Child/Adolescent

Date:_______________

REFERRER INFORMATION

Name of person making referral:____

Phone number:_________________________________

PATIENT INFORMATION

Name:__________________________________ Date of birth:_______________________

Address: ____

Phone number: _________________________ Medicaid ID#:_____________________

Medicaid MCO: ___Yes ___No MCO Name:_____________________

Consent to refer was provided by:
___ Parent ___ Guardian ___ Legal authorized representative
___Child/adolescent is over 18 OR if under 18, child/adolescent is a parent, is pregnant or is married

Reason for referral (check all that apply):

__Two or more chronic conditions
__Mental illness
__Serious emotional disturbance
__Complex trauma
__ HIV/AIDS
__Addiction
__Other

List chronic conditions:

____

How will this patient benefit from care management?

____

Fax this form to 845-255-3089, attn: Melissa Martinez;
or use a secure file-sharing service to send to memartinez@institute.org.

(877) 207-3387 CMPUlster.com