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?
_____

Send referral using a secure file-sharing service to Mandi Brown at mbrown@institute.org.