Mental Health Association

In

Orange County, Inc.

Reviewed By: _____

Date: _____

Date of Screening: _____

CARE COORDINATION REFERRAL FORM

Referral: ☐ **Referring Name _____**

Contact: ☐ **Phone** ☐ **In Person**

Medicaid? ☐ Yes ☐ No

Medicaid ID# :_____ **Insurance Name: _____**

Scheduled Intake Date & Time: _____ **CM: _____**

Applicant's Name: _____ DOB: _____

Address: _____

Tel. #: _____ **Alternate #: _____**

****Do they have any pets?_____ If yes, what kind? _____**

Health Home Eligibility:

(2 or more Chronic conditions OR 1 Single Qualifying Chronic condition – HIV/AIDS or Serious Mental Illness)

Please check & give brief description		Major Category
		Alcohol & Substance Use Disorder
		Mental Health
		Cardiovascular Disease
		Metabolic Disease
		Respiratory Disease
		Other

Medicaid Eligible? _____

Health Home Eligible?_____

Harp Eligible? _____

□ **Comments:**

_____

_____

_____

Fax/email this form to: Allison Davenport Fax # (845) 342-9665 or Email: adavenport@mhaorangeny.com