Horizon Health Services Care Coordination Referral Form

Contact Number (716) 508-7700 Fax Number (716) 508-7701

Enrollee Name: _____

Medicaid ID: _____

Enrollee DOB: _____

Enrollee Phone: _____

Other Phone Number Enrollee Can Be Reached: _____

Enrollee Address: _____

Reason for Referral: _____

Needs:

☐Homelessness ☐Inadequate Housing ☐Inadequate Food
☐Financial Assistance ☐Lack of Natural Supports ☐Lack of Daily Living Skills
☐Unaddressed Physical Health Needs ☐Unaddressed Behavioral Health Needs ☐Transition from Hospital
☐Non-adherence to Treatment ☐Non-adherence with Medications ☐Repeated ER/Inpatient Use
☐Transition from Incarceration in the Last 12 Months
☐Lack or inadequate Connection with Outpatient Care

Safety:

☐ Hx of Violence and/or Assault ☐Homicidal Ideation ☐Suicidal Ideation
☐Active Substance Abuse ☐Unsafe Living Environment

***2 Chronic Health Conditions*:**

☐Mental Health Condition-Diagnosis: _____ ☐Substance Use Disorder-Substance: _____

☐Asthma ☐Diabetes ☐Heart Disease ☐BMI>25 ☐Other Chronic Condition

Serious Mental Illness: YES NO Diagnosis: _____

HIV/AIDS: YES NO

Referring Person: _____ Date: _____

Contact Number: _____ Agency: _____

PLEASE FAX FORM TO (716) 508-7701