

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.