CATHOLIC CHARITIES
CARE COORDINATION SERVICES

REFERRAL FORM

Name _____

Date of Birth _____ Gender _____

Medicaid/CIN Number _____

Address _____

Phone _____

Chronic Illnesses (indicate as relevant):

☐ diabetes ☐ asthma ☐ HIV/AIDS ☐ mental health
☐ substance abuse ☐ heart disease ☐ overweight ☐ hypertension

☐ other, please specify: _____

Comments/Assessment of Needs: _____

_____

_____

_____

Date of Referral: _____

Referring Agency: _____

Contact Name: _____

Phone Number: _____

Email: _____

Is Release of Information Signed and Attached? ☐ **yes** ☐ **no**

FOR CC CARE COORDINATION SERVICES USE ONLY: Staff Initials _____

Date of First Contact: With Referral Source _____ With Client _____

Meet eligibility requirements for health home? ☐ yes ☐ no

If no, other referral or information provided _____

Date Referral Sent to CRHC: _____ Date Added to Roster: _____

CATHOLIC CHARITIES
CARE COORDINATION SERVICES

CONSENT FORM
FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize:

_____
(Name of agency and/or contact person)

_____
(Address of agency/contact person)

_____
(Phone number)

To disclose to/from: Catholic Charities Care Coordination Services
Outreach / Referral

(PLEASE CHECK ONE)

☐ Albany/ Rensselaer ☐ Columbia/Greene
☐ Schenectady/Saratoga ☐ Fulton/Montgomery ☐ Schoharie/Delaware/Otsego

The following information:
Information necessary to make referral for Care Coordination Services.

The purpose or need for such disclosure is:
To facilitate the referral process.

I understand that my records are protected under the Federal Confidentiality Regulations Law (42 CFR Part-2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

Specification of the date, event, or condition upon which this agreement expires:
When I enroll in the program or choose to opt out of these services.

_____

_____

Executed this _____ day of _____, 20_____.

_____ _____
(Signature of Client) (Signature of Witness)

_____
(Signature of parent/guardian, when required)