



**PRINT FORM**

**CLEAR FORM**

The **Hudson Valley Care** is a **FREE** service that helps people manage their medical needs, appointments, and social services, like housing and food. Hudson Valley Care provides people with a dedicated Care Manager who can team-up with doctors, specialist, and other providers to provide effective, efficient, and comprehensive care coordination.

**TO QUALIFY FOR THE HUDSON VALLEY CARE, AN INDIVIDUAL MUST MEET THE FOLLOWING CRITERIA:**

- Have Medicaid (active or eligible with pending application)**
- Have 1 or more of the following:**
  - 2 or more chronic medical conditions, such as mental health condition,
  - substance use disorder, asthma, diabetes, heart disease, BMI over 25,
  - other chronic conditions.
  - a Serious Mental Illness diagnosis
  - HIV/AIDS
- Be appropriate for health home services:**
  - Probable risk for adverse events (e.g. death, disability, inpatient or nursing home admission)
  - Lack of or inadequate social/family/housing support
  - Lack of or inadequate connectivity with healthcare system (e.g. no PCP, frequent ED visits or hospitalizations)
  - Non-adherence to treatments or medication(s) or difficulty managing medications
  - Recent release from incarceration or psychiatric hospitalization
  - Deficits in activities of daily living such as dressing or eating
  - Learning or cognition issues

**For more information, please contact HVC at 1-800-768-5080.**

For more information about Children Health Home Services call 1-888-980-8410, Option #4.

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To make a referral to the HVC, please fill out the information below about the individual you are referring:

Patient Name: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:    Male    Female    Medicaid ID Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Was the patient informed of the Health Home program?    Yes

Were you able to provide Health Home information for the patient to take home?    Yes    No

Did the patient provide his/her verbal consent to make the referral to the Health Home?    Yes

Name of person making referral: \_\_\_\_\_ Referring Phone Number: \_\_\_\_\_

Provider organization: \_\_\_\_\_

When complete, please send form via SECURE EMAIL to **Stephanie Griffith** at **sgriffith@hvcare.net**.  
If you do not have access to secure email, please fax the form to 914-941-3270.