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.

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 **Brianna Rodriguez** at **brrodriguez@hvcare.net**.
If you do not have access to secure email, please fax the form to 914-488-6707.