

# CONFIDENTIAL REFERRAL FORM

To: Program Assistant, Mid-Michigan CHAP Fax: 810.853.6826  
Phone: 810.953.CHAP(2427)



Date of Referral: \_\_\_\_\_  
From/Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Entity: \_\_\_\_\_ Fax: \_\_\_\_\_  
Medical Home: \_\_\_\_\_ PCP Name: \_\_\_\_\_

Client First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_  
If Client <18 yrs., Parent/Caregiver Name: \_\_\_\_\_ Caregiver DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Alternative Contact Name: \_\_\_\_\_ Alternate's Phone: \_\_\_\_\_  
Medicaid ID No. \_\_\_\_\_ ☐ Unknown  
Select one: ☐ Molina ☐ McLaren ☐ Meridian ☐ Blue Cross Complete ☐ United Healthcare ☐ HAP Empowered  
☐ Fee-for-Service ☐ Uninsured ☐ Commercial ☐ Medicare

## 1.0 SOCIAL DETERMINANT OF HEALTH NEEDS (check all that apply)

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Housing                   | <input type="checkbox"/> Employment Services         | <input type="checkbox"/> Depression       | <input type="checkbox"/> Document Acquisition Support |
| <input type="checkbox"/> Utilities                 | <input type="checkbox"/> Education/Job Training      | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Health Literacy              |
| <input type="checkbox"/> Household/Family Supports | <input type="checkbox"/> School or Education Support | <input type="checkbox"/> Stress           | <input type="checkbox"/> Child Care                   |
| <input type="checkbox"/> Food                      | <input type="checkbox"/> Financial                   | <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Healthy Lifestyles           |
| <input type="checkbox"/> Clean Water               | <input type="checkbox"/> Transportation*             | <input type="checkbox"/> Personal Safety  | <input type="checkbox"/> Health Education*            |
| <input type="checkbox"/> Legal Assistance          | *Please Specify _____                                |   |   |

## 2.0 HEALTHCARE ACCESS

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Access to PCP                   | <input type="checkbox"/> Access to Vision            | <input type="checkbox"/> Access to Specialist/Chronic Conditions (Specify): _____ | <input type="checkbox"/> Behavioral Health Services (Specify): _____ |
| <input type="checkbox"/> Access to Medication Management | <input type="checkbox"/> Frequent No Shows           | _____   | _____  |
| <input type="checkbox"/> Access to Home Care             | <input type="checkbox"/> Interpreter Services        | _____   | _____  |
| <input type="checkbox"/> Access to Dental                | <input type="checkbox"/> Maternal and Infant Health  | _____   | _____  |
| <input type="checkbox"/> At Risk of Dismissal            | <input type="checkbox"/> Access to Medical Equipment | _____   | _____  |

## 3.0 UTILIZATION

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High ED Use          | <input type="checkbox"/> Preventable ED Use | <input type="checkbox"/> Readmissions                    |
| <input type="checkbox"/> Inappropriate ED Use | <input type="checkbox"/> Dental ED Use      | <input type="checkbox"/> HEDIS Measures (Specify): _____ |

## 4.0 COVERAGE

- ☐ Insurance Coverage ☐ Prescription Coverage

## 5.0 SPECIAL PROJECTS

- ☐ Elevated Blood Lead Level (EBLL) ☐ City of Flint HUD Program ☐ OB

Additional Helpful Information:

\_\_\_\_\_

**CONFIDENTIALITY NOTICE:** This fax and any attachments are for the sole use of the identified recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, forwarding, or distribution is prohibited. If you are not the intended recipient, please contact the sender by phone and destroy all copies of the fax.