



Community Health Worker Referral

Fax To: 888-393-9235

Referring Clinic: _____ Phone # _____
Referring Staff Member: _____
Staff Member email address: _____

Patient Name: _____ Phone# _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____

Insurance Status (please circle): **Uninsured** **Private Insurance** **Medicaid** **CareNet**

If insured (public/private), please list _____
Carrier Name Policy Number

Please check any of the following areas the patient may need assistance with:

- | | |
|--|---|
| <input type="checkbox"/> Health Insurance/Medicaid Application | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Food | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Utilities | <input type="checkbox"/> Specialty Care |
| <input type="checkbox"/> Access to Medication | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Taking Medication Correctly | <input type="checkbox"/> Translation Assistance |
| <input type="checkbox"/> Frequent ER Visits | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Smoking Cessation | |

Any additional information regarding patient that may be helpful: _____

Office Use Only:

Date Received: _____ Assigned To: _____ 1st Contact: _____

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