# QCCP, LLC.

## *Queens Coordinated Care Partners*

External Health Homes Referral
*** To qualify for the Health Homes Program, an individual must have Medicaid:

- 2 or more Chronic conditions or
- A Serious Mental illness diagnosis or
- HIV/AIDS

**Patient Name:** _____ **Date of Referral:** _____ **DOB:** _____

**My Patient Receives Care at:**

**Jamaica Hospital** ____ **Community Healthcare Network** ___ **New York Hospital of Queens**__ **Mount Sinai** ___
Other_____

**Referring Provider Name:** _____ Title: _____

**Referring Provider Telephone #:** _____ **Institution Name:** _____

**Patient Address:** _____ **Gender:** ____ M ____ F **Race:** ____ White ____ Black ____ Hispanic ____ Asian Other: _____

_____

**City:** _____

**State:** _____ Zip: _____ **SS#:** _____/____/_____

**Phone:** _____ **Medicaid #:** _____ **Sequence#:** _____

**Emergency Contact:** _____ **Relation to Client:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____if patient is HIV+ is the emergency contact **Aware of Status:** _____

**What is the patient HIV Status? _____ Negative _____ Positive**
**Services Needed:**

____ Linkage to care
____ Appointment reminders
____ Treatment Adherence
____ Chronically Ill
____ GYN care
____TB Testing and Follow-up
____ Discharge Planning
____ Dental Care / Vision Care
____ Legal Services/specify: _____
____ Mental Health/Counseling
____ Family Therapy
____ Services for Minor Children
____ Substance Use Treatment
____ Harm Reduction Referrals
____ Support Groups/specify type: _____
____ Entitlements Assistance
____ Housing
____ other; specify: _____

**Other Pertinent Information:** _____

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**Please e-mail this form via CONFIDENTIAL E-MAIL to Oscar.Laluyan@mountsinai.org subject QCCP Referral**