



# Community Connections Confidential Referral

<b>From/Contact Person:</b>  <b>Referring Agency:</b>  <b>Phone:</b>  <b>Fax:</b>  <b>Date Referred:</b>  <b>Health Care Provider (if known):</b>	<b>To: Community Connections</b> <b>District Health Department #10 HUB</b> (Crawford, Kalkaska, Manistee, Missaukee, Wexford Lake, Mason, Mecosta, Newaygo, and Oceana Counties) <b>Fax: 1-231-622-7413 Phone: 1-888-217-3904 ext 3</b>  <b>Grand Traverse Regional HUB/Benzie-Leelanau District Health Department</b> (Benzie, Grand Traverse, and Leelanau Counties) <b>Fax: 1-231-882-0143 Phone: 1-833-674-2159</b>  <b>Health Department of Northwest Michigan HUB</b> (Antrim, Charlevoix, Emmet, and Otsego Counties) <b>Fax: 1-231-547-6238 Phone: 1-800-432-4121</b>  <b>District Health Department #4 HUB</b> (Alpena, Cheboygan, Montmorency, and Presque Isle Counties) <b>Fax: 1-989-354-0855 Phone: 1-800-221-0294</b>  <b>District Health Department #2 HUB</b> (Alcona, Iosco, Ogemaw, and Oscoda Counties) <b>Fax: 1-989-343-1896 Phone: 1-989-345-5020</b>  <b>Central Michigan District Health Department HUB</b> (Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon Counties) <b>Fax: 1-989-539-6731 Phone: 1-989-539-4449</b>  Date HUB Received: _____ ID #: _____
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**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Gender:** \_\_\_\_\_  
**Race:** American Indian or Alaska Native Asian Black or African-American Native Hawaiian or other Pacific Islander

White **Ethnicity:** Hispanic Non-Hispanic

**Parent/Guardian Name (if a minor):** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Alt. Phone:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

Preferred method of client contact:  Phone  Text \_\_\_\_\_

**Insurance:**  Meridian Medicaid  McLaren Medicaid  Molina Medicaid  Priority Health Medicaid  
 United Healthcare Medicaid  Straight Medicaid  Private  Medicare  Uninsured  Other

Is patient aware of referral?  Yes  No

**Reason for Referral:**

Medical/Social needs:

- |   |   |
|---|---|
| <input type="checkbox"/> At risk for dismissal _____        | <input type="checkbox"/> Dental referral  |
| <input type="checkbox"/> Primary care referral/medical home | <input type="checkbox"/> Behavioral Health referral                                 |
| <input type="checkbox"/> Transportation                     | <input type="checkbox"/> Health Education (specify): _____                          |
| <input type="checkbox"/> Utilities                          | <input type="checkbox"/> Housing  |
| <input type="checkbox"/> Food                               | <input type="checkbox"/> Medication Assessment/Management                           |
| <input type="checkbox"/> Health Insurance                   | <input type="checkbox"/> Basic needs: clothing, shoes, bedding, baby items, etc.... |
| <input type="checkbox"/> Child Care/Adult Care              | <input type="checkbox"/> Immunizations  |
| <input type="checkbox"/> Adult Education/Training           | <input type="checkbox"/> Employment   |
| <input type="checkbox"/> Financial Assistance/Medical Debt  | <input type="checkbox"/> Translation Assistance                                     |
| <input type="checkbox"/> Pregnancy Assistance               | <input type="checkbox"/> Postpartum Assistance                                      |
| <input type="checkbox"/> Developmental Screening/Referral   | <input type="checkbox"/> Legal Assistance   |

Other \_\_\_\_\_





Welcome to Community Connections. We can work together to help you and your family stay healthy!

Name \_\_\_\_\_

Name of Health Care Provider \_\_\_\_\_

Question	Yes	No
In the past month, did poor physical health keep you from doing your usual activities, like work, school or a hobby?		
In the past month did poor mental health keep you from doing your usual activities, like work, school, or a hobby?		
In the past 3 months, was there a time when you needed to see a doctor but could not because it cost too much?		
In the past 3 months, have you had to eat less than you feel you should because there is not food?		
Is it hard to find work or another source of income to meet your basic needs?		
Are you worried that in the next few months, you may not have housing?		
Has it been difficult to go to work or school because you couldn't find care for a child or older adult?		
Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be something you would like to work on in the next 6 months?		
Do you have trouble getting to school, work or the store because you don't have a way to get there?		
In the past 3 months, have you had a hard time paying your utilities?		
Have you been a patient in the Emergency Room 2 or more times in the past 6 months?		

You identified some needs today that may make being healthy very difficult. Would you like someone from our team to assist you in person, via phone or text to work on the needs that you identified today?  Yes  No **If yes, please fill out your contact information below.** Thank you.

Print Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian Name (If a minor): \_\_\_\_\_ County: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Primary phone: \_\_\_\_\_

Preferred method of client contact:  Phone  Text

Signature \_\_\_\_\_ Date: \_\_\_\_\_ Alt.phone: \_\_\_\_\_

Responsible Representative Name (Optional): \_\_\_\_\_ Phone: \_\_\_\_\_

(We will not share any information with the Responsible Representative unless you have signed permission to do so.)