# Community Connections Confidential Referral

| **From/Contact Person**:<br><br>**Referring Agency:**<br><br>**Phone**:<br><br>**Fax**:<br><br>**Date Referred**:<br><br>**Health Care Provider (if known)**: | **To: Community Connections**<br>**District Health Department #10 HUB**<br>(Crawford, Kalkaska, Manistee, Missaukee, Wexford Lake, Mason, Mecosta, Newaygo, Oceana Counties)<br>**Fax: 1-231-622-7413 Phone: 1-888-217-3904 ext 3**<br><br>**Grand Traverse Regional HUB/Benzie-Leelanau District Health Department**<br>(Benzie, Grand Traverse, Leelanau Counties)<br>**Fax: 1-231-882-0143 Phone: 1-833-674-2159**<br><br>**Health Department of Northwest Michigan HUB**<br>(Antrim, Charlevoix, Emmet, Otsego Counties)<br>**Fax**: **1-231-547-6238** **Phone**: **1-800-432-4121**<br><br>**District Health Department #4 HUB**<br>(Alpena, Cheboygan, Montmorency, and Presque Isle Counties)<br>**Fax: 1-989-354-0855 Phone: 1-800-221-0294**<br><br>Date HUB Received: ______________________<br>ID #: ______________________ |
|---|---|

**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:

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

☐ Other________________________________________________

Northern Michigan Community Health Innovation Region · Benzie-Leelanau District Health Department · District Health Dept #4 Providing A Healthier Tomorrow Since 1930 · District Health Department #10 Healthy People, Healthy Communities · Grand Traverse County Health Department · Health Department of Northwest Michigan

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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.)