

Please direct any questions or concerns to <name>

Date Order Written: _____

Patient Information:

Patient Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Phone:	<input type="text"/>
Address:	<input type="text"/>		

Referring Provider Information:

Provider: _____ Provider NPI: _____
Additional Providers: _____

Provider Orders for CHW Services:

Qualifying Condition(s): (Please check all that apply, if applicable)

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Musculoskeletal and neck/back disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Prediabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Risk Pregnancy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance Use Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Use of multiple medications (6 or more) |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mental Health Conditions | |

Qualifying Barrier(s): (Please check all that apply, if applicable)

- | | |
|--|---|
| <input type="checkbox"/> Geographic Distance from health services | <input type="checkbox"/> Cultural/language communication barriers |
| <input type="checkbox"/> Lack of phone/internet - Seeking care at incorrect location | <input type="checkbox"/> Social Determinant of Health (SDoH) barriers |
| <input type="checkbox"/> Other: _____ | |

CHW Objectives:

- Assess and assist with social determinants of health needs as related to qualifying condition(s) and/or qualifying barrier(s).
- Provide health system navigation and resource coordination as related to qualifying condition(s) and/or qualifying barrier(s).
- Provide health promotion and coach regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.
- Provide health education regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.

If the referral and service plan is not ordered by a recipient's Care Management Provider, or a dentist, the following written objective must be included:

- Establish or re-establish primary care for an annual wellness visit (at a minimum).
- Other: _____

CHW Services:

- Health system navigation and resource coordination
- Health promotion and coaching
- Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects.

Frequency and Duration of Services:

Work with patient up to 4 units per day (a unit is defined as 30 minutes) with a maximum of 20 units per week. Assess CHW services after six months, or prior if patient is ready to be discharged from CHW services.
Care plan must be reviewed, at minimum, every six months.

Provider Signature

Date

Once completed, please fax to:
<605-123-4567> Attn: CHW Program