<CHW Program Here and logo>
CHW Referral and Service Plan

<Program Address>
<Program Phone Number>
Please direct any questions or concerns to <name>

Date Order Written: _____

PATIENT INFORMATION

Patient Name: Date of Birth:
Gender: __ Male __ Female __ Other Phone:
Address:

REFERRING PROVIDER INFORMATION

Provider: Provider NPI:
Additional Providers:

PROVIDER ORDERS FOR CHW SERVICES

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

___ Asthma
___ Cancer
___ COPD
___ Depression
___ Diabetes
___ Heart Disease
___ Hypercholesterolemia
___ Hypertension
___ Mental Health Conditions
___ Musculoskeletal and neck/back disorders
___ Obesity
___ Prediabetes
___ High Risk Pregnancy
___ Substance Use Disorder
___ Tobacco use
___ Use of multiple medications (6 or more)
___ Other: _____.

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

___ Geographic Distance from health services
___ Lack of phone/internet - *Seeking care at incorrect location*
___ Cultural/language communication barriers
___ Social Determinant of Health (SDoH) barriers
___ Other: _____.

CHW OBJECTIVES

_X_ Assess and assist with social determinants of health needs as related to qualifying condition(s) and/or qualifying barrier(s).
_X_ 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

_X_ Health system navigation and resource coordination
_X_ Health promotion and coaching
_X_ 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