|  |  |
| --- | --- |
|  | Refugee Health Liaison Referral |

## Personal Information

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  |  |
|  | Last | First | M.I. |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: |  | Alternate Phone: |  |

|  |  |
| --- | --- |
| Referring Source | ❑ Resettlement Agency ❑ Ethnic Community-based Organization ❑ Self  ❑ Health Provider ❑ Other |
| Eligibility Status | ❑ Refugee ❑ Asylee ❑ Cuban/Haitian ❑ SIV ❑ URM |

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Arrival: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alien Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Resettlement Agency: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Case manager name : |  | Case manager’s contact information: |  |

## Health Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insurance Type: |  | Insurance ID #: | |  |
| Primary Care Physician/ Primary Care Clinic: |  | | Primary Care Physician contact: |  |
| Health/ Medical-Legal Needs: |  | | | |
|  |  | | | |
|  |  | | | |
|  |  | | | |

## Client’s Emergency Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  |  |
|  | Last | First | M.I. |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Phone: |  | Alternate Phone: |  |
| Relationship: |  | | |

For Refugee Health Liaison Use Only

❑ Eligibility verified by RRP ❑ not eligible, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date eligibility was verified by RRP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_