

SECTION 4: INSURANCE INFORMATION (if known)

Current Coverage (check all that apply):

- Medicare Advantage
- Medicare Supplement (Medigap)
- Medi Cal
- Dual Eligible (Medicare + Medi Cal)
- Other:
- Unknown / Needs assistance verifying coverage

Insurance Plan Name: _____

Medi-Cal #: _____

SECTION 5: REASON FOR REFERRAL (check all that apply)

- Care coordination / navigation
- Support managing chronic conditions
- Social needs support (housing, food, transportation, etc.)
- Caregiver support
- Transitions of care / post hospital support
- Health education and self management support
- Other (please describe): _____

Additional details or clinical context

SECTION 6: REFERRING PROVIDER/AGENCY

Referring Physician/Agency Name

Last Name

First Name

Email

Phone

Preferred Method of Follow-Up: Phone Email

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Providence Community Health Napa Valley - GUIDE Program

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