

HEALTHY PARTNERS REFERRAL FORM

APPLICANT INFORMATION	NAVIGATOR INFORMATION
Applicant Name:	Date of Referral:
Date of Birth:	Navigator Name:
Best Phone Contact (specify home, cell):	Agency:
Language Preference:	Phone:
Address:	Email:

REFERRAL CRITERIA		
1.	Age 19 +	☐ yes ☐ no
2.	Sacramento County Resident	☐ yes ☐ no
3.	Restricted Scope Medi-Cal Active	☐ yes ☐ no
<p>➤ If 1-3 are Yes: likely a good candidate for Healthy Partners. Send completed referral form via encrypted email to: DHS-PRI-HP@saccounty.gov</p> <p>➤ If 3 is No: Applicant must already have restricted-scope (emergency) Medi-Cal active before applying. While their Medi-Cal application is <i>pending</i>, they may receive services at the Sacramento County Health Center under the Sliding Fee Discount Program.</p> <p>➤ Call the Sacramento County Health Center, Member Services Team at: 916-874-1805 or email DHS-PRI-HP@saccounty.gov for questions.</p>		

<i>For Healthy Partners Member Services Only</i>
Date Received:
Disposition:
Notified Navigator: