Social Care Navigator Referral Form

Please send completed Social Care Navigator Referral to SocialCareReferrals@jfswny.org

*Client Name: ______________________________ *DOB: ________________

*Primary Phone Number: ______________________ Secondary Phone Number: ________________

Address: ___________________________________ *Medicaid CIN: _______________________

____

*Diagnoses:____

____

Suspected Health Related Social Needs: Please check the box for what services you believe are most appropriate for the client. The Social Care Navigators will direct them to the appropriate services if they are eligible.

Services with an asterisk can be provided directly through JFS

Housing*

Asthma Remediation

Home Accessibility and Safety Modifications

Community Transitional Supports*

Rent and Temporary Housing*

Utility Activation Fees*

Utility Back Payments*

Utility Assistance*

Nutrition

Counseling and Education

Medically Tailored Home Delivered Meals

jewish family services | wny

Pantry Stocking

Cooking Supplies

Transportation

Public and Private Transportation

Name of Referral Source: ________________________________

Title/Relationship to the Client: ______________________________

Date of Referral: __________________________________

Notes:

____

____

____

____

____

____

70 Barker St. | Buffalo, NY 14209 | 716.883.1914 | 716.883.7637 fx | jfswny.org