Healthy Homes Program Referral

sjohnston@orangecountync.gov

The Health Department will provide a **free** in-home assessment to help identify in housing-related health and injury hazards.

Our goal is to improve the health and quality of life for children with asthma by improving the indoor health and safety of their home environment. The purpose of a Healthy Homes visit is to identify health and injury hazards in a home, educate the occupants, parents, and caregivers on steps they can take, and provide resources to assist in the control of those hazards.

REFERRING ORGANIZATION **Date Sent:** ___/___/________

Person making referral (check one): ☐ School Nurse ☐ Medical Provider ☐ ED Navigator ☐ CC4C Nurse

Name: ____ Organization: ____

Phone: ________________ Fax: ______________________

To receive a participant's Assessment Report, you must be a HIPAA-Covered Entity

I am a HIPAA-Covered Entity (check one) ☐ Yes ☐ No ☐ Don't Know

Check if you do NOT want to receive an Assessment Report. ☐

CLIENT

Name: ________________________________ Date of Birth:_________

Parent/Guardian (IF APPLICABLE)__________________________________

Phone Number: ___________________ Back-up Number:________________

Street (Apt):____

City, State, Zip:____

Language Preference: ☐ English ☐ Spanish ☐ Other:______________

I give permission to share this information about my HOUSEHOLD with the health department and its partners, which may include nurses from the school, UNC Health Care, or Medicaid, Environmental Health, and a Family Suc-cess Alliance Zone Navigator, so they can contact me to conduct a home visit.

Doy permiso para que se comparta esta información sobre mi casa el departamento de salud y sus asociados, lo cual puede incluir a enfer-meras de la escuela,
UNC Health Care, Salude de Environmental, y Navegantes de Zona con la Alianza del Éxito Familiar, para que se puedan comunicar conmigo y lleven a cabo una visita a mi hogar.

PROGRAM ELIGIBILITY

The Healthy Homes serves community clients in Orange County.

Please check below if any conditions should be considered:

- ☐ Poorly-controlled persistent asthma, as diagnosed by a medical provider or identified by a school nurse
- ☐ Hospital admission for asthma exacerbation in past 12 mo. or repeated ED or urgent care visits for asthma within past 6 mo.
- ☐ Foodborne or vectorborne illness in the past 12 mo.
- ☐ Diagnosed sensitivity to mold or mold allergies

Client signature:____________________________________ Date:_______________

If no signature above, check the appropriate box below:

☐ *Parent/guardian is not available to sign the referral form, but is aware of the referral*

☐ *Parent/guardian is not aware they are being referred, but I believe they would benefit from it*

Note: Please acquire authorization from parent/guardian if possible. Lack of a signature above may delay services.

Signature of person making referral:__________________________________ Date:_______________