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Hello, this is Mr. Robert Stephens, Training Liaison Manager for the ***Office of Health Insurance Services*** [OHIS].

Attached is the latest revised referral form for use when referring children who may require health insurance assistance and other benefits that our office can provide. Indicated on this referral form is a space for the referring service coordinators to indicate their email address. This change is based as a result of recommendations from various Service Coordinators who expressed a need to receive confirmation when the parent/client is contacted by our OHIS Child Benefit Advisor [CBA].

Once contact has been made with the parent/ client, by our field staff (CBA), an email would then be sent to the referring service coordinator to confirm that contact has been made. We will however, continue to fax a confirmation to the service coordinator when we receive the initial referral from the Service Coordinators requesting assistance.

Also just to ensure that all possible attempts are made to get in contact with the parent whom you referred to us, our Child Benefit Advisors are instructed to contact you, if they are unable to get in touch with the parent.

Should you have any questions please feel free to contact me.

Robert Stephens, M.S.
Training Liaison Manager
Office Health Insurance Services
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New York City Department of Health and Mental Hygiene

The Office of Health Insurance Services [OHIS]

OHIS/Early Intervention Partnership

HEALTH INSURANCE AND OTHER BENEFITS FOR CHILDREN IN THE EARLY INTERVENTION PROGRAM

Referral for Health Insurance Services to a DOHMH Child Benefit Advisor [CBA]

Name of Provider Agency making Referral: ____

To Service Coordinators:

Please indicate below which services you wish to refer families to the Child Benefit Advisor.

- ☐ Child has no health insurance: [private or Medicaid] Family needs to apply for health insurance
- ☐ Family has private insurance, wants to apply for EXTRA medical coverage for the child
- ☐ Family wants assistance with their Medicaid Renewal
- ☐ Family interested in the Children with Special Health Care Needs Program (CSHCN)
- ☐ Child aging out non- Medicaid eligible, refer to (CSHCN)
- ☐ Family wants assistance with SSI and how to apply
- ☐ Family wants to apply for Food Stamps

FAMILY INFORMATION

Child's Name: ______________________________EI #: ____________________(D.O.B______________

Child's Name: ______________________________EI #: ____________________(D.O.B______________

Name of Parent or Guardian___________________________________Preferred Language_______________

Address:____Boro/Zipcode_________________

Phone Numbers: ____________________________________/_____________________________________

Best times to contact: Morning [ ] Afternoon [ ] Evenings

TO ALL SERVICE COORDINATORS: PLEASE COMPLETE REFERRAL INFORMATION AND FAX TO

646-672-2322

Referral Date: _________________________ Referred by: _____________________________________

SC Phone Number: ______________________ SC Fax Number: __________________________________

SC Email Address: ____

OHIS USE ONLY: Your referral has been received and confirmed by: ____

Date_________________________

SC referral revised 08/13