

How to Refer to the North Sound Community HUB

The Community HUB accepts referrals from medical and behavioral health providers, emergency departments, human services/social services, community-based organizations, community health workers, and community members.

During the 2019 launch of the North Sound Community HUB, we are accepting referrals via the Care Coordination Systems platform. Getting set up in CCS is easy, and referrals can be made immediately after setup.

1. Request login credentials to CCS by emailing hub@northsoundach.org.
2. Review this user guide.
3. [Login to CCS](#) and begin making referrals.

Using the CCS System to Make Referrals

Login to www.hub.carecoordinationsystems.com using your username and password.

CARE COORDINATION SYSTEMS

Log In

Welcome to
Pathways
HUB Connect

Please log in here to access your case records

User ID

Password

LOG IN

[Forgot your password?](#)

Bringing together the information and management resources you need to implement and track your clients' progress.

**BUILDING BETTER HEALTH,
ONE COMMUNITY AT A TIME**

Don't forget to enter your security password (your security question may be different).

First check to see if the client is already a participant of the HUB. **Caseload > Search Client**

- View Caseload
- Refer Client to HUB
- Search for Clients

CLIENT STATUS Active Inactive All

PRACTICE

PROVIDER

CLIENT TYPE

FUNDER

SEARCH BY Client Name

DATE OF BIRTH

NEXT VISIT FROM TO

LAST HOME VISIT FROM TO

LAST CONTACT FROM TO

ENROLLMENT Referral Ineligible Assigned Eligible Enrolled Could Not Locate Declined Services All

Clear Search

0 clients found

[Refresh Drop-Down Options](#)
[Reset Grid Customization](#)

Last	First	DOB	Age	Type	Enroll Date	ROI Renewal	Funder	Plan	CTD
------	-------	-----	-----	------	-------------	-------------	--------	------	-----

SEARCH FOR CLIENTS

Last

First

DOB

Search

RESULTS

No likely duplicates found.

[Add New Client](#)

Below is an example of a referral form; your HUB will provide a copy of their referral form.

Submit

Referral date:

Client has given consent to the referral source to share the information with the HUB for the purposes of enrollment into the care coordination program.
 Yes No

Referral Source *

Who is making the referral :
Referring person :

Other referral information :
Referral contact # :

Client Information *

Client Type * :
Insurance Status * :
First Name * :
Middle Name :
Last Name * :
Gender * :
Date of Birth * :
Marital Status :
Street Number * :
City * :
State * :

Marital Status Other :
Apt Number :
County * :
Zip Code * :

Client Information *

Type	Tag	Value	Notes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Remove](#)

Practice Group and Provider *:

Practice: Provider: Phone: Specialty:
Other Practice Group: Other practice group address:
Other Provider: Other provider address:

- Needs help with connection to (select all that apply) :
- Homeless/Housing
 - No Insurance
 - Mental Illness/Behavioral Health
 - Substance Use
 - Tobacco Use
 - No transportation
 - Childcare needs
 - Unwanted pregnancy
 - Less than 18 years old
 - Prior poor birth outcomes
 - Previous birth within last 18 months
 - Late entry into prenatal care (>13 weeks)
 - Unaware of the pregnancy
 - Poor health of the mother
 - Unmarried
 - Domestic violence
 - Personal problems
 - Primary Care needed
 - Specialty Care needed
 - Medication Assistance
 - Non-compliance with medical appointment
 - Low income
 - Food
 - Other

Referral Notes :