Enhanced Care Management (ECM) Referral Form for Adults

4665 Business Center Drive, Fairfield, CA
Care Coordination Phone: (800) 809-1350 • Fax: (530) 351-9040

Medi-Cal Member Information | ***Asterisk (*) indicates required information***	
Date of Referral*:	**Type of Referral*:** ☐ **Routine** ☐ **Expedited**
Member's Managed Care Plan*:	**Member Medi-Cal Client Index Number (CIN):**
Member First Name*:	**Member Last Name*:**
Member Date of Birth *(MM/DD/YYYY)****:**	**Member Phone Number*:**
Member Preferred Language:	**Member Primary Care Provider Name:**
Member Residential Address:	*Please check here for: No fixed current address. If available, please list frequently visited location for the member.* ☐
Member Residential City:	**Member Residential Zip Code:**
Member Email:	**Best Contact Method for Member/Caregiver:** ☐ **Phone** ☐ **Email**
Best Contact Time for Member/Caregiver:	**Parent/Guardian/Caregiver Name** *(if applicable)***:**
Parent/Guardian/Caregiver Phone Number *(if applicable)***:**	**Parent/Guardian/Caregiver Email** *(if applicable)***:**

Referral Source Information | ***Asterisk (*) indicates required information***	
Referring Organization Name*:	**Referring Organization National Provider Identifier (NPI):**
Referring Individual Name*:	**Referring Individual Relationship to Member*:** *Please select one of the following:* ☐ **Medical Provider** ☐ **Social Services Provider** ☐ **Member Self-Referred** ☐ **Other:** ______________________
Referring Individual Email Address*:	
Referring Individual Phone Number*:	

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Community Partners (Non-ECM Providers) Only

If the referring organization is a Community Partner (non-ECM provider), does the member have a preferred ECM provider?

Please select one of the following:

☐ Yes, this member has a preferred ECM provider

Preferred ECM Provider Organization: ______________________________

Preferred ECM Lead Care Manager (LCM): ___________________________

☐ No, the member does not have a preferred ECM provider

ECM Providers Only

If the referring organization is an ECM provider, does the referring organization recommend that the member be assigned to them as their ECM provider?

Please select one of the following:

☐ Yes, our organization should be this member's ECM provider

☐ No, this member should be assigned to a different ECM provider based on their needs.

☐ No, this member wants an alternative preferred ECM provider

Preferred ECM Provider Organization: _____________________________

Preferred ECM Lead Care Manager (LCM): ___________________________

ECM Providers with Presumptive Authorization Only

If the referring organization is an ECM provider that is eligible for presumptive authorization, does the member have an ECM benefit start date?

<u>ECM benefit start date is the date when billable ECM services were first provided to the member. This does not include outreach services.</u>

Please select one of the following:

☐ Yes, this member has an ECM benefit start date

ECM Benefit Start Date *(MM/DD/YYYY):* ______________________

☐ No, this member does not have an ECM benefit start date

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Member ECM Eligibility by Population of Focus

Adult (Age 21 or Older) ECM Eligibility – Check All That Apply

If the member being referred is an adult, please review each indicator and select the appropriate box to indicate "yes" to all those that apply across each Population of Focus.

Please leave blank all indicators that do not apply, to the extent of your knowledge.

☐ **HOMELESSNESS: Adults experiencing homelessness.**
(Note: To refer a homeless family to ECM, please use Children/Youth form)

☐ Member is experiencing homelessness (unhoused, in a shelter, losing housing in the next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence).

AND

☐ Member has at least one complex physical, behavioral, or developmental health need (includes pregnancy or post-partum, 12 months from delivery), for which the member would benefit from care coordination.

☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT UTILIZATION: Adults at risk for avoidable hospital or emergency department (ED) utilization.**

☐ Over the last six months, the member has had 5 or more emergency department visits that could have been avoided with appropriate care.

AND/OR

☐ Over the last six months, the member has had 3 or more unplanned hospital and/or short-term skilled nursing facility stays that could have been avoided with appropriate care.

☐ **LONG TERM CARE (LTC) INSTITUTIONALIZATION: Adults living in the community who are at risk for LTC institutionalization.**

Please confirm the member meets all the following criteria:

☐ Member is actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to: needing assistance with activities of daily living, communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring)

AND

☐ Member is able to reside continuously in the community with wraparound support.

AND

Member meets at least one of the following criteria:

☐ Living in the community and meets the Skilled Nursing Facility (SNF) level of care criteria.

☐ Requires lower-acuity skilled nursing, such as time limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness/injury.

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Check All That Apply

☐ **NURSING FACILITY RESIDENTS TRANSITIONING TO COMMUNITY: Adult nursing facility residents transitioning to the community.**

Please confirm the member meets <u>all</u> the following criteria:

☐ Member is a nursing facility resident who is interested in moving out of the institution.

AND

☐ Member is a likely candidate to move out of the institution successfully.

AND

☐ Member is able to reside continuously in the community.

☐ **SERIOUS MENTAL HEALTH / SUBSTANCE USE DISORDER: Adults with serious mental health and/or substance use disorder (SUD) needs.**

Please confirm Member meets <u>all</u> the following criteria:

☐ Member meets eligibility criteria for, and/or is obtaining services through:

- ☐ Specialty mental health services (SMHS) delivered by mental health plans: Significant impairment (distress, disability, or dysfunction in social, occupational, or other important activities) or a reasonable probability of significant deterioration in an important area of life functioning.
- ☐ Drug Medi-Cal Organization Delivery System (DMC-ODS): Have at least one diagnosis for substance-related and addictive disorder except for tobacco-related disorders and non-substance-related disorders.
- ☐ Drug Medi-Cal (DMC) Program: Have at least one diagnosis for substance-related and addictive disorder except for tobacco-related disorders and non-substance-related disorders.

AND

☐ Member is actively experiencing at least one complex social factor influencing their health, which may include, but is not limited to: lack of access to food; lack of access to stable housing; inability to work or engage in the community; former foster youth; or history of recent contacts with law enforcement related to mental health or substance use symptoms.

AND

Member meets <u>one or more</u> of the following criteria:

☐ High risk for institutionalization, overdose, and/or suicide

☐ Use crisis services, ED, Urgent Care, or inpatient stays as the primary source of care

☐ 2+ ED visits due to serious mental health or SUD in the past 12 months

☐ 2+ hospitalizations due to serious mental or SUD in the past 12 months

☐ Pregnant or post-partum (up to 12 months from delivery)

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Check All That Apply
☐ **JUSTICE INVOLVED: Adults transitioning from incarceration within the past 12 months.**

Please confirm member meets both of the following criteria:

- ☐ Member is transitioning from a correctional facility (e.g. prison, jail, or youth correctional facility), or transitioned from correctional facility within the past 12 months.

AND

Member has a diagnosis of at least one of the following conditions:

- ☐ Mental Illness
- ☐ Substance Use Disorder (SUD)
- ☐ Chronic Condition/Significant Non-Chronic Clinical Condition
- ☐ Intellectual or Developmental Disability (I/DD)
- ☐ Traumatic Brain Injury (TBI)
- ☐ HIV/AIDS
- ☐ Pregnant or Postpartum (up to 12 months from delivery)

☐ **BIRTH EQUITY: Pregnant and postpartum individuals at risk for adverse perinatal outcomes.**

Please confirm the member meets all the following criteria:

- ☐ Member is pregnant or postpartum (through 12 months period)

AND

- ☐ Member is subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality. As of 2024, Black, American Indian or Alaska Native, and Pacific Islander Members meet this criteria (referring individuals should prioritize member self-identification).

Additional Information

Please use this section to provide additional comments, as needed. This section is optional.

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Member Enrollment in Other Medi-Cal Programs and Services

Please use the table below to indicate other programs and services that the member is receiving under Medi-Cal.

Some Medi-Cal services may require coordination with ECM. Because other Medi-Cal services may offer support similar to ECM, members may be excluded from receiving ECM and these similar services at the same time. Partnership will review the information below and decide on the member's eligibility for ECM.

If there are any other care management or coordination program(s) in which the member is enrolled, to the extent known to the referring individual, that would require coordination with ECM (such as California Children's Services, Targeted Case Management within Specialty Mental Health Services, etc.) please share in the "Additional Information" section.

Please leave blank all elements that do not apply, to the extent of your knowledge.

☐ Dual Eligible Special Needs Plan (D-SNP)	☐ Hospice
☐ Fully Integrated Special Needs Plan (FIDE-SNP)	☐ Program for All Inclusive Care for the Elderly (PACE)
☐ Multipurpose Senior Services Program (MSSP)	☐ Assisted Living Waiver (ALW)
☐ Self-Determination Program for Individuals with I/DD	☐ Home and Community-Based Alternatives (HCBA) Waiver
☐ California Community Transitions (CCT)	☐ HIV/AIDS Waiver

Submission Information & Next Steps

By submitting this form, the referring individual attests to the best of their knowledge that the information in this form is correct.

Please submit the completed ECM Referral Form to Partnership via the options listed below. After submission, Partnership will make an ECM authorization decision. If the member is eligible, an ECM provider will reach out to the member to confirm interest in ECM and enroll in services.

Fax to:
(530) 351-9040

Email to:
ECM@partnershiphp.org

Fax and email options must be sent as "SECURE" - encrypted

Mail to:
Partnership HealthPlan of California
Attn. Enhanced Health Services Department
4665 Business Center Drive, Fairfield, CA 94534