Enhanced Care Management (ECM) Referral Form for Children/Youth

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?

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

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

Children/Youth (Under 21) ECM Eligibility Or Homeless Families - Check All That Apply

If the Member being referred is a child, youth or family (homelessness), please review each indicator and select the appropriate box to indicate yes to all those that apply across the child/youth Populations of Focus definitions, to help the managed care plan determine whether the individual qualifies for ECM and understand the child/youth/family's needs as fully as possible.

If you are referring a child/youth who is experiencing homelessness, and their family members or caretakers are also experiencing homelessness and have coverage through Medi-Cal, please consider referring all family members/caregivers for ECM services. Managed care plans are encouraged to work with ECM providers to serve a family unit together when referred for experiencing homelessness.

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

☐ **HOMELESSNESS: Homeless families or unaccompanied children/youth experiencing homelessness.**

Please confirm the member meets at least one of the following criteria:

☐ Child/youth or family with members under 21 years of age, who is experiencing homelessness (unhoused, in a shelter, losing housing in the next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence)

AND/OR

☐ Child/youth or family is sharing the housing of other persons (i.e. couch surfing) due to loss of housing, economic hardship, or a similar reason; or is living in a motel, hotel, trailer park, or camping ground due to the lack of alternative adequate accommodations; is living in emergency or transitional shelter; or is abandoned in hospital (in the hospital without a safe place to be discharged to)

☐ **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 (up to 12 months from delivery)

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).

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Check All That Apply
☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT USE: Children and youth at risk for avoidable hospital or emergency department utilization.**
Please confirm the Member meets <u>at least one</u> of the following criteria in the last 12 months: ☐ Child/youth has 3 or more emergency room visits that could have been avoided with appropriate care within the last 12 months **AND/OR** ☐ Child/youth has 2 or more unplanned hospital and/or short-term skilled nursing facility stays that could have been avoided with appropriate care, within the last 12 months
☐ **SERIOUS MENTAL HEALTH OR SUBSTANCE USE DISORDER: Children and youth with serious mental health and/or SUD needs.**
Please confirm the member meets eligibility criteria for and/or is obtaining services through at least one of the following: ☐ Specialty Mental Health Services (SMHS) delivered by mental health plans: Members under age 21 qualify to receive all medically necessary SMHS services. ☐ Drug Medi-Cal Organization Delivery System (DMC-ODS): Members under age 21 qualify to receive all medically necessary DMC-ODS services. ☐ Drug Medi-Cal (DMC) Program: Covered services provided under DMC shall include all medically necessary SUD services for individuals under 21 years of age.
☐ **CCS OR CCS WHOLE CHILD MODEL: Children/Youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition.**
Please confirm the member meets all the following criteria: ☐ Member is enrolled in CCS or CCS WCM; **AND** ☐ Member is experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health, former foster youth, and/or substance use symptoms.

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Check All That Apply

☐ **FOSTER CARE: Children/Youth involved in Child Welfare.**

Please confirm the member meets at least one of the following criteria:

☐ Member is under age 21 and is currently receiving foster care in California

AND/OR

☐ Member is under age 21 and previously received foster care in California or another state within the last 12 months

AND/OR

☐ Member is under age 26 and aged out of foster care (having been in foster care on their 18th birthday or later) in California or another state

AND/OR

☐ Member is under age 18 and eligible for and/or in California's Adoption Assistance Program

AND/OR

☐ Member is under age 18 and is currently receiving or has received services from California's Family Maintenance program within the last 12 months

☐ **JUSTICE INVOLVED: Children/Youth transitioning from a youth correctional facility.**

Please confirm the member meets the following criteria:

☐ Member is transitioning/transitioned from a youth correctional setting within the last 12 months

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