



## Enhanced Care Management (ECM) Member Referral Form Cal-AIM San Diego

Use this form to refer a member whom you assess as ECM eligible. **Please confirm the patient's health plan and submit this completed ECM referral form to the appropriate health plan via secure email or secure fax.** The health plan will assess the submitted member's eligibility and respond with next steps or request more information within one week

Health Plan	Secure Email Address	Secure Fax Number
Aetna		
Blue Shield Promise Health Plan		
Community Health Group		
Health Net		
Kaiser Permanente		
Molina Healthcare		

***Asterisk (\*) identifies required information field on this ECM referral form***

Member Information	
Date:*	
Member's Name:*	
Member Date of Birth:*	
Member's Medi-Cal Client Identification #: * <i>(9 digit number ending with an letter)</i>	
Member Address:	
Member Primary Phone Number:*	(    )
Best time to contact:	
Member's Preferred Language:*	
Caregiver's Name:	
Caregiver's Alternate Phone Number	(    )

<b>Referral Source Information</b>	
Date:*	
Internal referring department* (select one): <input type="checkbox"/> Case Management <input type="checkbox"/> Utilization Management <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Managed Long Term Services & Supports (MLTSS) <input type="checkbox"/> Other	
External referral by* (select one): <input type="checkbox"/> Hospital <input type="checkbox"/> Preferred Provider Group (PPG) <input type="checkbox"/> Primary Care Provider (PCP) <input type="checkbox"/> Clinic <input type="checkbox"/> Other	
Referring Individual Name:*	
Referring Organization Name:*	
Referrer Phone Number:*	(    )
Referrer Email Address:*	
Has the member expressed interest in enrolling in ECM?*	
<input type="checkbox"/> Yes <input type="checkbox"/> No, I would like to validate ECM eligibility prior to discussing ECM with the member.	
Is the member currently being followed by a health plan case manager or part of an external case management program? * <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, please provide contact information as available:	
Is the member experiencing any housing insecurities/homelessness? * <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	
<b>For the purposes of the ECM program DHCS defines homelessness as:</b>	
<ul style="list-style-type: none"> <li>• <i>An individual or family who lacks adequate nighttime residence</i></li> <li>• <i>An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation</i></li> <li>• <i>An individual or family living in a shelter</i></li> <li>• <i>An individual exiting an institution to homelessness<sup>2</sup></i></li> <li>• <i>An individual or family who will imminently lose housing in next 30 days<sup>3</sup></i></li> <li>• <i>Unaccompanied youth and homeless families and children and youth defined as homeless under other Federal statutes</i></li> <li>• <i>Victims fleeing domestic violence</i></li> </ul>	
<ol style="list-style-type: none"> <li>1. <i>This definition is based on the HUD definition of homelessness with modifications as noted below.</i></li> <li>2. <i>If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.</i></li> <li>3. <i>The timeframe for an individual or family who will imminently lose housing has been extended from 14 (HUD definition) to 30 days.</i></li> </ol>	

<b>MEDI-CAL ELIGIBILITY:*</b>	Member in Medi-Cal managed care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Member in Cal MediConnect? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, member is <b>NOT</b> eligible for ECM

**Populations of Focus\*:** Please check **all** that apply. For a patient to be eligible for the ECM, they must meet at least one of the following criteria. The individual will be assessed by the Plan to confirm ECM eligibility.

Population of focus definitions below

**Individuals & Families Experiencing Homelessness**

Yes  No  Unknown

1) Experiencing homeless – based on the HUD definition with modifications

**AND**

2) Have at least 1 complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

*(Please see page 4 for additional details as to how DHCS is defining homelessness)*

**Adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD)**

Yes  No  Unknown

1) Meet the eligibility criteria for program participation or currently receiving services through:  
Services provided by the County of San Diego:

- The County Specialty Mental Health (SMH) System AND/OR
- The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program

**AND**

2) are actively experiencing at least one complex social factor influencing their health

**AND**

3) meet one or more of the following criteria:

- High risk for institutionalization, overdose and/or suicide;
- Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care;
- Two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months;
- Pregnant and post-partum women (12 months from delivery).

**Adults High Utilizers**

Yes  No  Unknown

1) 5 or more ER visits within a 6 month period that could have been avoided

**AND/OR**

2) 3 or more unplanned hospital or short-term skilled nursing facility stays in a 6 month period that could have been avoided

ECM will coordinate all care for the highest-risk Members with complex medical and social needs, including across the physical and behavioral health delivery systems. Many Members who will be eligible for ECM may already be receiving some care management through other programs.

Please select all programs the member is currently participating in, if known:\*

<b>1915 c Waivers</b>	<b>Services Carved Out of Managed Care Plans</b>	<b>Duals</b>	<b>Others</b>
<input type="checkbox"/> Yes <i>Multipurpose Senior Services Program (MSSP)</i>	<input type="checkbox"/> Yes <i>California Children’s Services (CCS)</i>	<input type="checkbox"/> Yes <i>Dual Eligible Special Needs Plans (D-SNPs) [from 2023]</i>	<input type="checkbox"/> Yes <i>AIDS Healthcare Foundation Plans</i>
<input type="checkbox"/> Yes <i>Assisted Living Waiver (ALW)</i>	<input type="checkbox"/> Yes <i>Genetically Handicapped Person’s Program (GHPP)</i>	<input type="checkbox"/> Yes <i>D-SNP look-alike plans</i>	<input type="checkbox"/> Yes <i>California Community Transitions (CCT) Money Follows the Person (MFTP)</i>
<input type="checkbox"/> Yes <i>Home and Community Based Alternatives (HCBA) Waiver</i>	<input type="checkbox"/> Yes <i>County-Based Targeted Case Management (TCM)</i>	<input type="checkbox"/> Yes <i>Other Medicare Advantage Plans</i>	
<input type="checkbox"/> Yes <i>HIV/AIDS Waiver</i>	<input type="checkbox"/> Yes <i>Specialty Mental Health (SMHS) TCM</i>	<input type="checkbox"/> Yes <i>Medicare FFS</i>	<input type="checkbox"/> Yes <i>Hospice</i>
<input type="checkbox"/> Yes <i>HCBS Waiver for Individuals with Developmental Disabilities (DD)</i>	<input type="checkbox"/> Yes <i>SMHS Intensive Care Coordination for Children (ICC)</i>	<input type="checkbox"/> Yes <i>Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)</i>	<input type="checkbox"/> Yes <i>Mosaic Family Services</i>
<input type="checkbox"/> Yes <i>Self-Determination Program for Individuals with I/DD</i>	<input type="checkbox"/> Yes <i>Drug Medi-Cal Organized Delivery System (DMC-ODS)</i>	<input type="checkbox"/> Yes <i>Programs for All-Inclusive Care for the Elderly (PACE)</i>	

Additional comments, if any