Integrity • Accountability • Collaboration • Trust • Respect

ENHANCED CARE MANAGEMENT (ECM)
REFERRAL FORM

MEMBER INFORMATION

Please print or type

Last Name: ____________________ First Name: ____________________ Date: ____________

Mailing Address: ____________________ City: ____________________ Zip: ____________

Medi-Cal ID: ____________________ Phone: ____________________ Birth Date: ____________

Language Preference: ☐ English ☐ Spanish ☐ Other: ____________________

REFERRAL SOURCE INFORMATION

Last Name: ____________________ First Name: ____________________

Mailing Address: ____________________ City: ____________________ Zip: ____________

Phone: ____________________ Email: ____________________

RELATION TO MEMBER: ☐ Self ☐ Parent / Guardian ☐ Family / Friend ☐ Primary Care Provider (PCP) ☐ ECM Provider ☐ Other Service Provider ☐ GCHP Staff ☐ Community Based Organization (CBO)

PREFERRED CONTACT METHOD: ☐ Email ☐ Phone ☐ Mail

REFERRING ORGANIZATION (if applicable):

HAS MEMBER BEEN INFORMED THAT A REFERRAL WAS BEING SUBMITTED? ☐ Yes ☐ No

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

All Ages	Adults (21+)	Children / Youth (under 21)
☐ Homeless or at risk of becoming homeless ☐ Serious Mental Illness ☐ Substance Use Disorder ☐ 3+ ER visits in 12 months ☐ 2+ unscheduled hospital or nursing facility stays in 12 months ☐ Diagnosis of Intellectual or Developmental Disability	☐ Individuals Transitioning from Incarceration ☐ Adult Nursing Facility Residents Transitioning to the Community ☐ Adults Living in the Community and At Risk for LTC Institutionalization	☐ Justice Involved (transitioning from correctional facility or involved with probation services) ☐ Children and Youth Enrolled in CCS with Additional Needs Beyond the CCS Condition ☐ Children and Youth Involved in Child Welfare Services

REASON FOR REFERRAL

What is your concern?	
Desired outcome or result:	
Additional Information:	