ECM REFERRAL FORM — ADULT

Please complete sections 1–6. If there is a required section that you are unable to complete, please contact CalOptima Health Customer Service toll-free at 1-800-587-8088 (TTY 711) for additional support prior to submission. CalOptima Health is here Monday through Friday from 8 a.m. to 5:30 p.m. The call is free. Visit online at www.caloptima.org. You can get this ECM Referral Form and other plan materials in other languages for free. CalOptima Health provides written translations from qualified translators. Call 1-888-587-8088 (TTY 711). The call is free.

1. MEMBER INFORMATION *Asterisk (*) indicates required information.*	
Date of Referral*	
Type of Referral*	☐ Routine ☐ Expedited
Member's Managed Care Plan*	
Member First Name*	
Member Last Name*	
Member Medi-Cal Client Index Number (CIN)	
Managed Care Plan Member ID Number	
Member Date of Birth (MM/DD/YYYY)*	
Member Primary Phone Number*	
Member Preferred Language	
Member Primary Care Provider Name	
Member Residential Address	☐ Please check here if there's no fixed current address. If available, list the Member's frequently visited locations.
Member Residential City	
Member Residential ZIP Code	

Member Email	

1. MEMBER INFORMATION (cont.) *Asterisk (*) indicates required information.*	
Best Contact Method for Member/Caregiver (if applicable)	☐ 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)	

2. REFERRAL SOURCE INFORMATION	
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)	
Referring Individual Name*	
Referring Individual Title	
Referring Individual Phone Number*	
Referring Individual Email Address*	
Referring Individual Relationship to Member*	☐ Medical Provider ☐ Social Services Provider ☐ Other: **Please provide additional details in Section 5 — Additional Comments**

COMMUNITY PARTNERS (NON-ECM PROVIDERS ONLY)	**Does the Member have a preferred ECM Provider?** Please select one of the following: ☐ Yes, this Member has a preferred ECM Provider Preferred ECM Care Manager _____ Preferred ECM Provider Organization _____

2. REFERRAL SOURCE INFORMATION (cont.)	
	☐ No, this Member does not have a preferred ECM Provider
ECM PROVIDERS ONLY	**Does the referring organization recommend being assigned as the Member's ECP Provider?** Please select one of the following: ☐ Yes, our organization should be the Member's ECM Provider ☐ No, our organization recommends this Member be assigned to a different ECM Provider based on their needs **Please provide additional details in Section 5 — Additional Comments.** ☐ No, this Member wants an alternative preferred ECM Provider Preferred ECM Care Manager _____ Preferred ECM Provider Organization _____

3. 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 indicate yes to all those that apply across each Population of Focus (POF). ***Please leave blank all indicators that do not apply, to the extent of your knowledge.*** *Please use Section 5 — Additional Comments to note any areas where further CalOptima Health review may be warranted. For additional guidance on the ECM POF definitions, please refer to the ECM Policy Guide.*

If you are uncertain if a Member is eligible for ECM, please contact CalOptima Health Customer Service toll-free at **1-800-587-8088** (TTY **711**). CalOptima Health is here Monday through Friday from 8 a.m. to 5:30 p.m. The call is free. Visit online at *www.caloptima.org*.

☐ **HOMELESSNESS: Adults Experiencing Homelessness**

(Note: To refer a homeless family to ECM, please use the Children/Youth section)

Please confirm the Member meets the following criteria:

☐ Adult Members (whether or not they have dependent children/youth living with them) who are experiencing homelessness defined as meeting one or more of the following conditions: lacking a fixed, regular, and adequate nighttime residence; having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing; exiting an institution into homelessness (regardless of length of stay in the institution; will imminently lose housing in next 30 days; fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;

AND

☐ Member has at least one complex physical, behavioral or developmental need with an 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 (includes pregnancy or post-partum, 12 months from delivery).

OR

☐ Members authorized for Transitional Rent.

☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT UTILIZATION: Adults at Risk for Avoidable Hospital or ED Utilization**

Please confirm the Member meets one or more of the following criteria:

☐ Five or more emergency department (ED) visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

AND/OR

☐ Three or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

☐ **SERIOUS MENTAL HEALTH/SUBSTANCE USE: Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs**

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS (cont.)

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

☐ Meet eligibility criteria for participation in, or obtaining services through:

- ☐ Specialty Mental Health Services (SMHS) delivered by MHPs;
- ☐ Drug Medi-Cal Organization Delivery System (DMC-ODS) **or**,
- ☐ Drug Medi-Cal (DMC) Program;

AND

☐ Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of Adverse Childhood Events (ACEs) based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms);

AND

☐ One or more of the following criteria:

- ☐ Are at high risk for institutionalization, overdose, and/or suicide;
- ☐ Use crisis services, EDs, urgent care or inpatient stays as the primary source of care;
- ☐ Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months.

☐JUSTICE INVOLVED: Adults Transitioning from Incarceration within the past 12 months

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

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

AND

☐ Has at least one of the following conditions: mental illness, SUD, chronic condition/significant non-chronic clinical condition, intellectual or developmental disability (I/DD), traumatic brain injury (TBI), HIV/AIDS, pregnant or postpartum.

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

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

- ☐ Is living in the community and meets skilled nursing facility (SNF) Level of Care criteria or 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 or injury;

  AND

- ☐ 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

- ☐ Is able to reside continuously in the community with wraparound supports.

☐ **NURSING FACILITY RESIDENTS TRANSITIONING TO THE COMMUNITY: Adult Nursing Facility Residents Transitioning to the Community**

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

- ☐ Is a nursing facility resident who is interested in moving out of the institution;

  AND

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS (cont.)

- ☐ Is a likely candidate to move out of the institution successfully;

  AND

- ☐ Is able to reside continuously in the community.

☐ **BIRTH EQUITY: Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes**

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

☐ Is pregnant or postpartum (through 12 months period);

AND

☐ Is subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

4. ENROLLMENT IN OTHER PROGRAMS AND SERVICES (OPTIONAL)

Please use the **optional** 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. CalOptima Health will review the information below and make a determination on the Member's eligibility for ECM. CalOptima Health is responsible for determining eligibility for ECM, not the referring individual.

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 additional information in Section 5 — Additional Comments. **Please leave blank all elements that do not apply to the extent of your knowledge.**

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

5. ADDITIONAL COMMENTS:

Please use this section to provide additional comments on Sections 1–4, as needed.	

6. SUBMISSION INFORMATION & NEXT STEPS

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

Please submit the completed ECM Referral Form to CalOptima Health by email at CalAIMReferral@caloptima.org or fax at 1-714-338-3145. After submission, CalOptima Health will make an ECM authorization decision within 7 calendar days for routine referrals and within 72 hours for expedited referrals. If the member is eligible, an ECM Provider will reach out to the member to confirm interest in ECM and enrollment in services.

ECM REFERRAL FORM — CHILD/YOUTH

Please complete sections 1–6. If there is a required section that you are unable to complete, please contact CalOptima Health Customer Service toll-free at 1-800-587-8088 (TTY 711) for additional support prior to submission. CalOptima Health is here Monday through Friday from 8 a.m. to 5:30 p.m. The call is free. Visit online at *www.caloptima.org*. You can get this ECM Referral Form and other plan materials in other languages for free. CalOptima Health provides written translations from qualified translators. Call 1-888-587-8088 (TTY 711). The call is free.

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

Parent/Guardian/Caregiver Phone (if applicable)	
Parent/Guardian/Caregiver Email (if applicable)	

2. REFERRAL SOURCE INFORMATION	
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)	
Referring Individual Name*	
Referring Individual Title	
Referring Individual Phone Number*	
Referring Individual Email Address*	
Referring Individual Relationship to Member*	☐ Medical Provider ☐ Social Services Provider ☐ Other: **Please provide additional details in Section 5 — Additional Comments**
COMMUNITY PARTNERS (NON-ECM PROVIDERS ONLY)	**Does the Member have a preferred ECM Provider?** Please select one of the following: ☐ Yes, this Member has a preferred ECM Provider Preferred ECM Care Manager _____ Preferred ECM Provider Organization _____ ☐ No, this Member does not have a preferred ECM Provider

ECM PROVIDERS ONLY	**Does the referring organization recommend being assigned as the Member's ECP Provider?** Please select one of the following: ☐ Yes, our organization should be the Member's ECM Provider ☐ No, our organization recommends this Member be assigned to a different ECM Provider based on their needs **Please provide additional details in Section 5 — Additional Comments.** ☐ No, this Member wants an alternative preferred ECM Provider Preferred ECM Care Manager _____ Preferred ECM Provider Organization _____

3. 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 mark all those that apply across the child/youth Populations of Focus definitions, to help CalOptima Health determine whether the individual qualifies for ECM and understands the child/youth/family's needs as fully as possible. Please leave blank all indicators that do not apply, to the extent of your knowledge.

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 Managed Care, 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.

If you are uncertain if a Member is eligible for ECM, please contact CalOptima Health Customer Service toll-free at **1-800-587-8088** (TTY **711**). CalOptima Health is here Monday through Friday from 8 a.m. to 5:30 p.m. The call is free. Visit online at *www.caloptima.org*.

☐ **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 are experiencing homelessness defined as meeting one or more of the following conditions: lacking a fixed, regular, and adequate nighttime residence; having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing; exiting an institution into homelessness (regardless of length of stay in the institution; will imminently lose housing in next 30 days; fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;

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 hospital without a safe place to be discharged to);

OR

☐ Members authorized for Transitional Rent.

☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT USE: Children and Youth At Risk for Avoidable Hospital or ED Utilization**

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

☐ Child/youth has three or more Emergency Department visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

AND/OR

☐ Child/youth has two or more unplanned hospital and/or short-term skilled nursing facility stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

☐ **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 MHPs

☐ Drug Medi-Cal Organization Delivery System (DMH-ODS) or the Drug Medi-Cal (DMC) Program

☐ **JUSTICE INVOLVED: Children/Youth Transitioning from a Youth Correctional Facility**

Please confirm the Member meets the following criteria:

☐ Children and youth under 21 or former foster youth between 18 and 26 who are transitioning from a youth correctional setting or adult jail/prison or transitioned from being in a youth correctional facility or adult jail/prison within the last 12 months

☐ **CCS OR CCS WHOLE CHILD MODEL: Children/Youth Enrolled in California Children's Services (CCS)or CCS WCM with Additional Needs Beyond the CCS Condition**

Please confirm the Member meets all of the following criteria:

☐ Is enrolled in CCS or CCS WCM;

AND

☐ 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.

☐ **FOSTER CARE: Children/Youth Involved in Child Welfare**

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

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

AND/OR

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

AND/OR

☐ 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

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

AND/OR

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

☐ **BIRTH EQUITY: Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes**

Please confirm the Member meets all of the following criteria:

☐ Is pregnant or postpartum (through 12 months period);

AND

☐ Is subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

4. ENROLLMENT IN OTHER PROGRAMS AND SERVICES

Please use the **optional** 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. CalOptima Health will review the information below and make a determination on the Member's eligibility for ECM. CalOptima Health is responsible for determining eligibility for ECM, not the referring individual.

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

5. ADDITIONAL COMMENTS:

Please use this section to provide additional comments on Sections 1–4, as needed.	

6. SUBMISSION INFORMATION AND NEXT STEPS

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

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