Enhanced Care Management Program
Member Referral Form

Enhanced Care Management (ECM) is a Medi-Cal benefit that provides comprehensive care management services to Medi-Cal members with complex health and/or social needs. To be eligible for ECM, members must qualify for one or more of the identified **ECM Populations of Focus** and are not enrolled in duplicative services (as defined in the ***Exclusionary Screening Checklist***). Members enrolled in ECM will primarily receive in-person care management/care coordination services that will be provided in the member's community by contracted ECM provider agencies who have elected to serve the member's specific Populations of Focus. ECM providers can serve more than one Populations of Focus.

Use this form to refer a member whom you assess as ECM-eligible. **Please confirm the member's Health Plan and submit this completed ECM *Program Member Referral Form* via secure fax (Fax Number: 800-743-1655).**
Health Net* will assess the submitted member's eligibility and respond with next steps or request more information within one week.

There are three steps to the screening and referral process:

1. First, **complete the *Populations of Focus Screening Checklist*** to confirm member eligibility.
2. Next**, complete the *Exclusionary Screening Checklist*** to confirm eligibility and identify duplicative programs for which the member must choose and potential programs that the member can be enrolled in while also in ECM, which will require coordination of services.
3. If the member **is determined to be eligible for ECM** based on **both *screening checklists***, complete the ***ECM Program Member Referral Form*** (include any additional information to support eligibility) and send securely to the member's Health Plan for review.

Asterisk(*) identifies required information field on this ECM Referral Form.

REFERRAL SOURCE INFORMATION	
Internal referring department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Other: _____	
External referral by* (select one): ☐ Hospital ☐ PPG ☐ PCP ☐ Clinic ☐ Other: _____	
Referring individual name:*	
Referring organization name:*	
Referrer phone number:*	( )
Referrer email address:*	
Has the member expressed interest in opting into ECM?	☐ Yes, I have already discussed the program with the member. Comments: ☐ No, I would like to validate ECM eligibility prior to discussing ECM with the member.

MEMBER INFORMATION			
Member name:*			
Member Medi-Cal client ID number (CIN):*		Member date of birth:*	
Member address:			
Member primary phone number:*	( )	Best time to contact:	
Member preferred language:*			
Caregiver name:		Caregiver's alternate phone number:	( )

Member's ECM eligibility (attach ECM *Populations of Focus Screening Checklist*) **Check all that apply:***	
☐	Individuals experiencing **homelessness**
☐	**High utilizers** with frequent hospital or emergency room (ER) admissions
☐	Individuals transitioning form **incarceration**
☐	Individuals with **serious mental illness/substance use disorder** (**SMI/SUD)** and other health needs

Exclusionary criteria (please complete and refer to ECM *Exclusionary Screening Checklist*) **ALL boxes** must be checked for member eligibility for ECM*	
☐	Member is **not enrolled in programs** that would exclude the member from eligibility for ECM
☐	Member is enrolled in a duplicate program and is **opting** for **ECM instead of** the other program
☐	**N/A or** member is enrolled in a program that allows them to **concurrently** receive ECM services. **Please note program(s):**

ADDITIONAL COMMENTS (include additional social determinants of health considerations, such as food, housing, employment insecurity, history of ACES/trauma, history of recent contacts with law enforcement, former foster youth)