HealthPlan OF SAN MATEO
801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

Enhanced Care Management Child/Youth Referral Form

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible Members with complex needs. The purpose of this ECM Referral is to collect key information about the Member, so that their MCP can confirm if the Member is eligible for ECM. If the Member is eligible for ECM, their MCP will assign the Member to an ECM Provider who supports the Member's specific Population(s) of Focus.

To receive ECM, Medi-Cal Members must meet DHCS eligibility criteria for at least one of the Populations of Focus (POF) described in the ECM Referral Form. Members can be eligible for more than one POF, so please review and complete information for all applicable POFs for a Member's age group.

Please complete sections 1-6 of this form as a fillable PDF, then submit as outlined in section 6. For assistance completing the form or eligibility questions, please contact HPSM Care Coordination/Integrated Care Management by calling 650-616-2060 or visiting www.hpsm.org/provider/calaim/ecm.

Asterisk (*) indicates required information.

Type of Referral:* ◯ Routine ◯ Urgent **Date of Referral:***

SECTION 1 MEMBER INFORMATION

Member's Managed Care Plan: Health Plan of San Mateo

First Name:* _____ **Last Name:*** _____

Medi-Cal Client Index Number (CIN): _____ **HPSM Member ID #:** _____

Date of Birth:* _____ **Phone:*** _____ **Primary Language:** _____

Name of Primary Care Provider: _____

MEMBER/PARENT/CAREGIVER CONTACT INFORMATION

☐ **Member has no fixed residential address** (If available, please enter a frequently visited location)

Member's Address: _____

Member's Email: _____

Parent/Caregiver's Name (if applicable): _____

Parent/Caregiver Address (if applicable): _____

Parent/Caregiver Phone (if applicable): _____

Parent/Caregiver Email (if applicable): _____

Preferred Method of Contact: ☐ Phone ☐ Email **Best Time to Contact:** _____

SECTION 2 BEGINS ON NEXT PAGE ▶

SECTION 2 REFERRAL SOURCE INFORMATION

Name of Referring Organization:* _____ **NPI #:** _____

Name of Referring Individual:* _____ **Title:** _____

Phone:* _____ **Email Address:*** _____

Relationship to Member:* ☐ Medical Provider ☐ Social Services Provider

☐ Other (Please provide additional detail in Section 5 – Additional Comments)

NON-ECM PROVIDERS AND COMMUNITY PARTNERS 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 that the Member be assigned to it as their ECM Provider?

◯ **Yes**, our organization should be the Member's ECM Provider

◯ **No**, our organization recommends this Member is assigned to a different ECM Provider based on their needs (Please provide additional detail in Section 5 – Additional Comments).

◯ **No**, this Member wants an alternative preferred ECM Provider

Preferred ECM Care Manager: _____

Preferred ECM Provider Organization: _____

ECM PROVIDERS WITH PRESUMPTIVE AUTHORIZATION ONLY

The ECM Benefit Start Date is the date when billable ECM services were first provided to the Member. This does not include outreach services.

Does the Member have an ECM Benefit Start Date?

◯ **Yes**, this Member has an ECM Benefit Start Date

ECM Benefit Start Date: _____

◯ **No**, this Member does not have an ECM Benefit Start Date

SECTION 3 BEGINS ON NEXT PAGE ▶

SECTION 3 MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

If the Member being referred is a child, youth or family (homelessness), please review each indicator and indicate yes to all those that apply across the child/youth Populations of Focus definitions, to help HPSM 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 Managed Care, please consider referring all family members/caregivers for ECM services. MCPs are encouraged to work with ECM Providers to serve a family unit together when referred for experiencing homelessness.

Check all that apply to the extent of your knowledge.

☐ HOMELESSNESS: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness

Please confirm the Member meets <u>at least one</u> of the following criteria. Check all that apply:

☐ Child/youth or family with Members under 21 years of age, who is experiencing homelessness (unhoused, in a shelter, losing housing in 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 hospital without a safe place to be discharged to).

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

Please confirm the Member meets <u>at least one</u> of the following criteria <u>in the last 12 months</u>.

☐ 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 <u>at least one</u> of the following:

☐ Specialty Mental Health Services (SMHS) delivered by MHPs: Members under age 21 qualify to receive all medically necessary SMHS services.

☐ Drug Medi-Cal Organization Delivery System (DMH-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.

SECTION 3 CONTINUES ON NEXT PAGE ▶

☐ 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.

☐ 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 <u>all</u> of 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.

☐ FOSTER CARE: Children/Youth Involved in Child Welfare

Please confirm the Member meets <u>at least one</u> of the following criteria. Select all that apply:

☐ 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 is 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.

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

Please confirm the Member meets <u>all</u> of the following criteria. Select all that apply:

☐ 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 are included in this definition (referring individuals should prioritize Member self-identification.

SECTION 4 BEGINS ON NEXT PAGE ▶

SECTION 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. The Managed Care Plan will review the information below and make a determination on the Member's eligibility for ECM. HPSM 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 in Section 5 – Additional Comments.

Check all that apply to the extent of your knowledge:

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

SECTION 5 BEGINS ON NEXT PAGE ▶

SECTION 5 ADDITIONAL COMMENTS

Please use this section to provide additional comments from Sections 1 through 4, as needed.

SECTION 6 BEGINS ON NEXT PAGE ▶

SECTION 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 HPSM Care Coordination/Integrated Care Management by email (preferred method) or fax:

Email: CareCoordinationRequests@hpsm.org
Fax: 650-829-2047

After submission, HPSM will make an ECM authorization decision within five business days for routine requests or within 72 hours for urgent requests. If the Member is eligible, an ECM Provider will reach out to the Member to confirm interest in ECM and enroll in services.

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