

CALIFORNIA INTEGRATED CARE MANAGEMENT (CICM) REFERRAL FORM

ADULTS 21+ YEARS OF AGE

Send to CareManagement_Referrals@sfhp.org



OVERVIEW

California Integrated Care Management is a California-specific requirement for integrated care coordination for specific vulnerable populations covered by Dual Eligible Special Needs Plans (D-SNPs) as determined by the state. The purpose of this CICM Referral is to collect key information about the Member, so that their MCP can confirm if the Member is eligible for CICM. If the Member is eligible for CICM, their MCP will assign the Member to a CICM Provider who supports the Member's specific Population(s) of Focus.

THIS FORM IS INTENDED TO REFER AN ADULT (Age 21 Years and Older) CICM SERVICES.

For children or youth, please refer to the Children and Youth Referral Form.

ELIGIBILITY CRITERIA

Please use this form for SFHP Care Plus members only. Members who qualify under **at least one** of the CICM Populations of Focus (POF) will be approved for CICM services and will be assigned to a SFHP Care Plus contracted CICM Provider.

To be eligible for CICM, a member must already be enrolled in D-SNP. Members must **not** be enrolled in exclusionary programs or receiving duplicative services. Refer to exclusionary terms on page 5 for a full list.

OBJECTIVE AND GENERAL INSTRUCTIONS

Return this completed Referral Form via SECURE email to SFHP Care Plus at CareManagement_Referrals@sfhp.org or fax to **(415) 615-6400**. Allow up to **5 business days** for the form to be reviewed. The SFHP Care Plus Care Management Intake Team will notify you of the results.

Fields marked with an asterisk (*) are required. Please complete Sections 1–6. If there is a required section that you are unable to complete, please contact us at CareManagement_Referrals@sfhp.org for additional support prior to submission.

1. MEMBER INFORMATION

Member must already be enrolled in Medi-Medi or Medi-Cal. Asterisk (*) indicates required information.

Date of Referral*:	Type of Referral*:	Routine	Expedited
Member's Managed Care Plan*:			
Member First Name*:	Member Last Name*:		
Member Date of Birth (MM/DD/YYYY)*:	SFHP Care Plus Member ID Number:		
Member Preferred Language:	Member Medicare Beneficiary Identification Number (MBI):		
Member Primary Phone Number*:	Other Preferred Method of Contact:		
Preferred Name/Pronoun (if applicable):			
Alternate Contact Name (if applicable):	Alternate Phone Number:		
Member Primary Care Provider Name:	Member Residential Address:		
Please check here for: No fixed current address.	Member Residential City:	Zip Code:	
If available, please list frequently visited location for the Member:			
Member Email:	Best Contact Method for Member/Caregiver:	Phone	Email
Best Contact Time for Member/Caregiver:	Parent/Guardian/Caregiver Name:		
Parent/Guardian/Caregiver Phone Number:	Parent/Guardian/Caregiver Email:		

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2. REFERRAL SOURCE INFORMATION

Asterisk (*) indicates required information.

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

Referring Individual Phone Number*: _____ Referring Individual Email Address*: _____

Referring Individual's Relationship to Member* (Select one):
Medical Officer Other – Please describe:
Social Services Provider

Referring Organization Name*: _____

Referring Organization National Provider Identifier* (NPI): _____

Are You an Active SFHP CICM Provider? No – Proceed to Section 2A Yes – Proceed to Section 2B

2A. COMMUNITY PARTNERS (Non-CICM Providers Only)

Does the Member have a preferred CICM Provider? (Please select one of the following)

Yes, this Member has a preferred CICM Provider.
Preferred CICM Provider Organization: _____ Preferred CICM Care Manager: _____

No, this Member does not have a preferred CICM Provider.

2B. COMMUNITY PARTNERS (CICM Providers Only)

Does the referring organization recommend that the Member be assigned to it as their CICM Provider? (Please select one of the following)

Yes, our organization should be the Member's CICM Provider.
No, our organization recommends this Member is assigned to a different CICM Provider based on their needs.
Please provide additional detail in Section 5 – Additional Comments.

No, this member wants an alternative preferred CICM Provider, as indicated below:
Preferred CICM Provider Organization: _____ Preferred CICM Care Manager: _____

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3. MEMBER CICM ELIGIBILITY BY POPULATION OF FOCUS

ADULT (AGE 21 OR OLDER) CICM 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.

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 MCP review may be warranted. For additional guidance on the CICM POF definitions, please refer to the CalAIM D-SNP Policy Guide. If you are uncertain if a Member is eligible for CICM, please contact us at CareManagement_Referrals@sfhp.org.

HOMELESSNESS: Adults Experiencing Homelessness (Note: To refer a homeless family to CICM, please use the Children and Youth Referral Form). Please confirm the Member meets **both** of the following criteria:

Member is experiencing Homelessness (unhoused, in a shelter, losing housing in next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence).

– AND –

Member has at least one complex physical, behavioral, or developmental health need (includes pregnancy or postpartum, 12 months from delivery), for which the Member would benefit from care coordination.

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

Please confirm the Member meets **at least one** of the following criteria:

Over the last 6 months, the Member has had 5 or more emergency room visits that could have been avoided with appropriate care.

–AND/OR–

Over the last 6 months, the Member has 3 or more unplanned hospital and/or short-term Skilled Nursing Facility stays that could have been avoided with appropriate care.

SERIOUS MENTAL HEALTH/SUBSTANCE USE: Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)

Please confirm the Member meets **all** of the following criteria:

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:
Significant impairment (distress, disability, or dysfunction in social, occupational, or other important activities) OR a reasonable probability of significant deterioration in an important area of life functioning.

Drug Medi-Cal Organization Delivery System (DMC-ODS): Have at least one diagnosis for Substance-Related and Addictive Disorder with the exception of Tobacco-related disorders and non-substance-related disorders.

Drug Medi-Cal (DMC) Program: Have at least one diagnosis for Substance-Related and Addictive Disorder with the exception of Tobacco-related disorders and non-substance-related disorders.

– AND –

Member is actively experiencing at least one complex social factor influencing their health, which may include, but is not limited to: lack of access to food; lack of access to stable housing; inability to work or engage in the community; former foster youth; or history of recent contacts with law enforcement related to mental health or substance use symptoms.

– AND –

Member meets **one or more** of the following criteria:

High risk for institutionalization, overdose, and/or suicide
Use crisis services, ERs, Urgent Care, or inpatient stays as the primary source of care

2+ ER visits or 2+ hospitalizations due to Serious Mental Illness or SUD in the past 12 months
Pregnant or postpartum (up to 12 months from delivery)

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

Please confirm the Member meets **both** of the following criteria:

Member 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 –

Member has a diagnosis of **at least one** of the following conditions:

- | | |
|--|---|
| Mental illness | Intellectual or Developmental Disability (I/DD) |
| Substance Use Disorder (SUD) | Traumatic Brain Injury |
| Chronic Condition/Significant Non-Chronic Clinical Condition | HIV/AIDS |
| disease (for example: hepatitis C, diabetes) | Pregnancy or Postpartum (up to 12 months from delivery) |

LONG TERM CARE (LTC) INSTITUTIONALIZATION: Adults Living in the Community Who Are at Risk for LTC Institutionalization

Please confirm the Member meets **all** of the following criteria:

Member meets **at least one** of the following criteria:

- | | |
|--|---|
| Living in the community and who meets the Skilled Nursing Facility (SNF) Level of Care (LOC) criteria. | Requires lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services. |
|--|---|

– AND –

Member 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 (ADLs), 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 –

Member is able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

NURSING HOME RESIDENTS TRANSITIONING TO THE COMMUNITY: Adult Nursing Facility Residents Transitioning to the Community

Please confirm the Member meets **all** of the following criteria:

Member is a likely candidate to move out of the institution successfully.

– AND –

Member is able to reside continuously in the community.

ADULTS WHO ARE PREGNANT/POSTPARTUM & SUBJECT TO RACIAL & ETHNIC DISPARITIES

Please confirm the Member meets **all** of the following criteria:

Member is pregnant or postpartum (through 12-months period).

– 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, Alaska Native, or Pacific Islander Members are included in this definition (referring individuals should prioritize Member self-identification).

DEMENTIA: Adults with Documented Dementia Need

Please confirm the Member meets **all** of the following criteria:

Member must have a formal diagnosis of Dementia or Alzheimer's or documented Dementia needs.

– OR –

Have documented dementia care needs, including but not limited to: Wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, AND/OR inability to manage ADLs/IADLs.

● If you find that there is **not** a qualifying Population of Focus (POF), please stop here and do not submit the form. If you have questions, email SFHP Care Plus at CareManagement_Referrals@sfhp.org.

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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 CICM. Because other Medi-Cal services may offer support similar to CICM, Members may be excluded from receiving CICM 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 CICM. The Managed Care Plan is responsible for determining eligibility for CICM, 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 CICM (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 with (I/DD)
Assisted Living Waiver (ALW)	California Community Transitions (CCT)
Home and Community-Based Alternatives (HCBA) Waiver	HIV/AIDS Waiver

5. ADDITIONAL COMMENTS (OPTIONAL):

Please use this section to provide additional comments on Sections 2, 3, and 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 CICM Referral Form to the Member's Managed Care Plan (SFHP CARE PLUS) via secure email. After submission, SFHP Care Plus will make a CICM authorization decision within five business days. If the Member is eligible, a CICM Provider will reach out to the Member to confirm interest in CICM and enroll in services.

Signature:

Today's Date (MM/DD/YYYY):