ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

ADULTS 21+ YEARS OF AGE

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

OVERVIEW:

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.

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

For children or youth, please refer to the Children and Youth referral form.

ELIGIBILITY CRITERIA:

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

To be eligible for ECM, a member must already be enrolled in Medi-Cal Managed Care or have Medicare with Managed Care Medi-Cal as their secondary medical coverage. 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 at **CareManagement_Referrals@sfhp.org.** Allow up to **5 business days** for the form to be reviewed. The SFHP 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 Member ID Number:	
Member Preferred Language:	Member Medi-Cal Client Index Number (CIN):	
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:	Member Residential City:	Zip Code:
Please check here for: ☐ No fixed current address.		
If available, please list frequently visited location for the Member:		
Member Email:	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):	

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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 ☐ Social Services Provider ☐ Other – Please provide additional detail in Section 5 – Additional Comments.

Referring Organization Name*:

Referring Organization National Provider Identifier (NPI):

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

2A. 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 Provider Organization:	Preferred ECM Care Manager:

☐ No, this Member does not have a preferred ECM Provider.

2B. COMMUNITY PARTNERS (ECM Providers Only)

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

☐ 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, as indicated below:

Preferred ECM Provider Organization:	Preferred ECM Care Manager:

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.

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 ECM POF definitions, please refer to the ECM Policy Guide.

If you are uncertain if a Member is eligible for ECM, please contact us at **CareManagement_Referrals@sfhp.org.**

☐ **HOMELESSNESS: Adults Experiencing Homelessness**

(Note: To refer a homeless family to ECM, 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 post-partum, 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 six months, the Member has had 5 or more emergency room visits that could have been avoided with appropriate care.

–AND/OR–

☐ Over the last six 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) Needs**

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 post-partum (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
- ☐ Substance Use Disorder (SUD)
- ☐ Chronic Condition/Significant Non-Chronic Clinical Condition disease (for example, hepatitis C, diabetes)
- ☐ Intellectual or Developmental Disability (I/DD)
- ☐ Traumatic Brain Injury
- ☐ HIV/AIDS
- ☐ 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 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 nursing facility resident who is interested in moving out of the institution.

–AND–

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

–AND–

☐ Member 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 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).

● 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 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 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. The Managed Care Plan 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 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 ECM Referral Form to the Member's Managed Care Plan (SFHP) via **secure email**. After submission, SFHP will make an ECM authorization decision within five business days. If the Member is eligible, an ECM Provider will reach out to the Member to confirm interest in ECM and enroll in services.

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