ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

CHILDREN AND YOUTH - AGES 20 YEARS AND UNDER

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
Here for you

ECM offers comprehensive case management services to individuals who are enrolled in Medi-Cal Managed Care or have Medicare with Managed Care Medi-Cal, who:

1) Have complex health and/or social needs, and

2) Meet the eligibility criteria, as outlined on this form.

ECM is an opt in benefit that is intended to serve the highest-need members and provides intensive coordination of health services.

THIS FORM IS TO REFER A CHILD/YOUTH (Age 20 years and under) TO ECM SERVICES.
For adults, please refer to the Adult Referral Form

ELIGIBILITY CRITERIA:

Use this form for SFHP members only. Members who qualify under **at least one** of the ECM Populations of Focus (POF) may be approved and will then be assigned 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 secondary medical coverage. Members must **not** be enrolled in exclusionary programs or receiving duplicative services. Refer to exclusionary terms on page 3 for a full list.

OBJECTIVE AND GENERAL INSTRUCTIONS:

Return this completed referral form via SECURE email to SFHP at CareManagement_Referrals@sfhp.org. Allow **5 business days** for the form to be reviewed. The SFHP Care Management Intake Team will notify you of the results.

MEMBER/PATIENT INFORMATION

Member must already be enrolled with SFHP for their Medi-Cal coverage

First Name:	Last Name:
Date of Birth (MM/DD/YYYY):	SFHP ID#:
Preferred Language:	Medi-Cal Client ID (CIN):
Primary Phone Number:	Other Preferred Method of Contact:
Preferred Name/Pronoun (If applicable):	
Alternate Contact Name (If applicable):	Alternate Phone Number:

REFERRING PROVIDER OR REFERRING PERSON'S INFORMATION

Name of Person Submitting This Referral:	
Agency or Referring Organization's Name (If applicable):	
Are You an Active SFHP ECM Provider? ☐ Yes ☐ No	
Phone Number:	Email:

ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

CHILDREN AND YOUTH - AGES 20 YEARS AND UNDER

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™

Here for you

ECM QUALIFYING POPULATIONS OF FOCUS FOR CHILDREN AND YOUTH (20 YEARS OLD AND UNDER)

Please mark the checkbox(es) next to at least **one** of the required qualifying Population of Focus (POFs) – check all that apply

☐ **Children/Youth Experiencing Homeless** (Must meet one of the criteria below)

- ☐ Homeless/unhoused
- ☐ Chronically homeless
- ☐ At risk of homelessness

☐ **Children/Youth High Utilizers** (Must meet one of the criteria below)

- ☐ 3 or more emergency room visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence

–OR–

- ☐ 2 or more unplanned hospital and/or short-term SNF stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence

☐ **Children/Youth with Severe Mental Illness (SMI) or Substance Use Disorder (SUD)** (Must meet one of the criteria below)

Must be eligible for participation in, or obtaining services through one of more of the following:

- ☐ Specialty Mental Health

–OR–

- ☐ The DMC-ODS or the DMC program

Link: Screening and Transition of Care Tools for Medi-Cal Mental Health Services

☐ **Children/Youth with Intellectual or Developmental Disabilities (I/DD)** (Must meet both of the criteria below)

- ☐ Have a diagnosed I/DD

–AND–

- ☐ Qualify for eligibility in any other children and youth ECM POF

☐ **Children/Youth – California Children's Services (CCS) or CCS Whole Child Model (WCM) With Additional Needs (beyond the CCS condition)**

- ☐ Are enrolled in CCS or CCS WCM

–AND–

- ☐ Are experiencing at least one complex social factor influencing their health

*Examples include (but are not limited to the following):

- 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
- Crisis intervention services related to mental health and/or substance use symptoms)

☐ **Children/Youth Involved in Child Welfare** (Must meet at least one of the following. Check all that apply.)

- ☐ Are under age 21 and are currently receiving foster care in California
- ☐ Are under age 21 and previously received foster care in California or another state within the last 12 months
- ☐ Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
- ☐ Are under age 18 and are eligible for and/or in California's Adoption Assistance Program
- ☐ Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

CHILDREN AND YOUTH - AGES 20 YEARS AND UNDER

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
Here for you

ECM QUALIFYING POPULATIONS OF FOCUS FOR CHILDREN AND YOUTH (20 YEARS OLD AND UNDER) (continued)

Please mark the checkbox(es) next to at least **one** of the required qualifying Population of Focus (POFs) – check all that apply

☐ **Pregnant, Postpartum, & Birth Equity for Children/Youth** (Must meet both criteria for this POF)

- ☐ Pregnant OR postpartum through 12 months after last day of pregnancy. Applies to live birth, termination, and pregnancy loss

–AND–

- ☐ Qualify for eligibility in any other youth ECM POF

–OR–

- ☐ Who self-identify as Black, American Indian, Alaska Native, or Pacific Islander

Note: This specific population is identified as experiencing disparities in care for maternal morbidity and mortality based on California public health data. Adults who are pregnant and up to 12 months after last day of pregnancy and who do not identify as one of the above racial/ ethnic groups are eligible for ECM **ONLY** if they meet criteria for any of the other Populations of Focus (POF) listed on this form.

☐ **Justice-Involved Children/Youth Transitioning from Incarceration** (Must meet criteria below)

- ☐ Released from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months

● 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 **CareManagement_Referrals@sfhp.org**

ECM EXCLUSIONARY TERMS

If any of these criteria apply to the member, please **do not** proceed with submitting a referral

1. A member is **not** eligible for ECM if any of the following criteria apply:
   a. Member is enrolled in D-SNP (Dual Special Needs Plan)
   b. Member is enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPS)
   c. Member is enrolled in Program for All Inclusive Care for the Elderly (PACE)
   d. Member is enrolled in Mosaic Family Services
   e. Member is enrolled in Hospice
   f. Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF) and subacute care facilities.
   g. Members residing in Intermediate Care Facilities (ICF) and subacute care facilities.
2. Please also ensure that the member is **not** enrolled in an ECM Duplicative Program. If the member is enrolled in another program, and is opting for ECM instead of the other program, please indicate the known Program(s):
   - ☐ 1915(c) Waiver Programs: Home and Community Based (HCBS)
   - ☐ HIV/AIDS
   - ☐ Assisted Living Waiver (ALW)
   - ☐ Developmentally Disabled (DD)
   - ☐ Multipurpose Senior Services Program (MSSP)
   - ☐ Complex Case Management

ATTESTATION STATEMENT

Both checkboxes must be marked to be considered a completed referral

☐ **I, the referent, attest that to the best of my knowledge; the member is not enrolled in programs that exclude the member from ECM eligibility. If member is enrolled in an ECM duplicative program, I attest that the member is opting for ECM instead of the other program.**

☐ **I, the referent, attest that to the best of my knowledge, the member meets Population of Focus criteria as listed on this form.**

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

For general ECM program inquiries, email **CalAIMECMILOS@sfhp.org**