ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

CHILDREN AND YOUTH – AGES 20 AND UNDER

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 TO REFER A CHILD/YOUTH (Age 20 Years and Under) TO ECM SERVICES.

For adults, please refer to the Adult 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 secondary medical coverage. Members must not be enrolled in exclusionary programs or receiving duplicative services. Refer to exclusionary terms on page 4.

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:

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3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

CHILDREN/YOUTH (UNDER 21) ECM ELIGIBILITY OR HOMELESS FAMILIES – CHECK ALL THAT APPLY

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 the MCP determine whether the individual qualifies for ECM and understand the child/youth/family's needs as fully as possible. **Please leave blank all indicators that do not apply, to the extent of your knowledge.**

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.

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

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

Please confirm the Member meets AT LEAST ONE of the following criteria:

☐ 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 AT LEAST ONE of the following criteria in the last 12 months:

☐ Child/youth has had 3 or more emergency room visits that could have been avoided with appropriate care within the last 12 months.

–AND/OR–

☐ Child/youth has had 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 Severe Mental Health and/or SUD Needs**

Please confirm the 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:** Members under age 21 qualify to receive all medically necessary SMHS services.

☐ **Drug Medi-Cal Organization Delivery System (DMC-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.

☐ **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 Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition**

Please confirm the Member meets ALL 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 AT LEAST ONE of the following criteria:

☐ 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 have 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 ALL of the following criteria:

☐ 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, 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.**

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:

Please use this section to provide additional comments on Sections 2 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):