

Please return completed referral form and required supporting documentation via **SECURE** email to [ECM@scfhp.com](mailto:ECM@scfhp.com) or fax to 1-408-874-1469. Allow up to five (5) business days for a routine referral and three (3) business days for an expedited referral to be reviewed once received.

**Questions?** Please email [ECM@scfhp.com](mailto:ECM@scfhp.com)

**Eligibility for ECM:** To receive ECM, Medi-Cal members must meet eligibility criteria for at least one of the Populations of Focus (POF) described later in the ECM Referral Form. Members can be eligible for more than one POF, so please review and complete information for all POFs.

Patient/Member Information	
Date of Referral:	Type of Referral: <input type="checkbox"/> Routine <input type="checkbox"/> Expedited
Member's Managed Care Plan:	Member's PCP:
Member's Medi-Cal CIN:	
First Name:	Last Name:
DOB:	Phone:
Email:	Preferred Language:
Member Residential Address:	
Parent/Guardian/Caregiver Information	
Best Contact Method for Member/Caregiver: <input type="checkbox"/> Phone <input type="checkbox"/> Email	Best Contact Time for Member/Caregiver:
Name <i>(required)</i> :	
Phone Number <i>(required)</i> :	
Email <i>(if applicable)</i> :	
Referral Source Information	
Referring Organization Name:	
Referring Organization National Provider Identifier (NPI):	
Referring Individual Name:	Referring Individual Title:
Referring Individual Phone:	Referring Individual Email:
Referring Individual Relationship to Member:	<input type="checkbox"/> Medical Provider <input type="checkbox"/> Social Services Provider <input type="checkbox"/> Other
Is referring agency a SCFHP ECM Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Community Partners (Non-ECM Providers) ONLY.</u> Does the Member have a preferred ECM Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<u>ECM Providers ONLY.</u> Does the referring organization recommend assigning the Member to their ECM organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>ECM Provider with Presumptive Authorization ONLY.</u> Does the Member have an ECM Benefit Start Date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional Comments (Optional):</b>	

### **Eligibility Criteria**

**To qualify for ECM, the member must be enrolled in Medi-Cal and meet the requirements below:**

<b>1. Member is <u>not</u> enrolled in a program or service included in the ECM Exclusions below:</b>	
<ul style="list-style-type: none"> <li>• Multipurpose Senior Services Program(MSSP)</li> <li>• Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)</li> <li>• Home and Community-Based Alternatives (HCBA) Waiver</li> <li>• Hospice</li> </ul>	<ul style="list-style-type: none"> <li>• Self-Determination Program for Individuals with I/DD.</li> <li>• Dual Eligible Special Needs Plan (D-SNP)</li> <li>• Assisted Living Waiver (ALW)</li> <li>• Program for All-Inclusive Care for the Elderly (PACE)</li> <li>• California Community Transitions (CCT)</li> <li>• HIV/AIDS Waiver</li> </ul>
<b>2. If the Member being referred is a child, youth, or family (homelessness), please review each indicator and indicate yes to <u>all</u> those that apply across the child/youth Populations of Focus. <b>Please leave blank all elements that do not apply, to the extent of your knowledge.</b> Please use the free text area to note any areas where further MCP review may be warranted. For additional guidance on the ECM POF definitions, please refer to the <a href="#">ECM Policy Guide</a>.</b>	
<input type="checkbox"/> <b>Unaccompanied Children/Youth Experiencing Homelessness</b>	
<input type="checkbox"/> <b><u>OR</u> Homeless Families</b> <u>Must meet at least one of the following criteria:</u>	
<input type="checkbox"/> Child/youth or family with Members under 21 years of age, who is experiencing homelessness (unhoused, in a shelter, losing housing in the next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence)	
<input type="checkbox"/> <b><u>OR</u></b> 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 shelters; or is abandoned in hospitals (in hospital without a safe place to be discharged to)	
<input type="checkbox"/> <b>Children and Youth at Risk for Avoidable Hospital or ED Utilization</b> <u>Must meet at least one of the following criteria:</u>	
<input type="checkbox"/> Child/youth has (3) or more emergency room visits that could have been avoided with appropriate care within the last 12 months	
<input type="checkbox"/> <b><u>OR</u></b> 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	
<input type="checkbox"/> <b>Children and Youth with Serious Mental Health (SMI) and/or Substance Use Disorder (SUD) Needs</b> <u>Must meet eligibility criteria for, and/or is obtaining services through at least one of the following:</u>	
<input type="checkbox"/> Specialty Mental Health Services (SMHS) delivered by MHPs: Members under age 21 qualify to receive all medically necessary SMHS services.	
<input type="checkbox"/> 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.

☐ **Children/Youth Transitioning from a Youth Correctional Facility**

- ☐ Member is transitioning/transitioned from a youth correctional setting within the last 12 months

☐ **Children/Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model with Additional Needs Beyond the CCS Condition**

Must meet all of the following criteria:

- ☐ Member is enrolled in CCS or CCS WCM
- ☐ **AND** Member is experiencing at least (1) 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.

☐ **Children/Youth Involved in Child Welfare**

Must meet at least one of the following criteria:

- ☐ Member is under age 21 and is currently receiving foster care in California
- ☐ Member is under age 21 and previously received foster care in California or another state within the last 12 months
- ☐ 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
- ☐ Member is under age 18 and eligible for and/or in California's Adoption Assistance Program
- ☐ Member is under age 18 and is currently receiving or has received services from California's Family Maintenance program within the last 12 months

☐ **Children/Youth - Birth Equity**

Must meet 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, please select one of the following:
- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> African American        | <input type="checkbox"/> Chinese    |
| <input type="checkbox"/> American Indian         | <input type="checkbox"/> Samoan     |
| <input type="checkbox"/> Alaskan/Native American | <input type="checkbox"/> Hawaiian   |
| <input type="checkbox"/> Pacific Islander        | <input type="checkbox"/> Guamanian  |
| <input type="checkbox"/> Hispanic                | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Filipino                | <input type="checkbox"/> Other      |

## Supporting Documents

The following supporting documents are **required** to be submitted with each referral. Check all that apply and attach to this referral.

- ☐ Recent Chart Notes ☐ Care Plan ☐ ECM Nursing Facility Transition Assessment ☐ Other

Referrer's Signature:

Date Referral Sent: