Enhanced Care Management (ECM) Referral Form

Email: ECM@scfhp.com
Fax: **1-408-874-1469**

Return completed referral form and all applicable documentation via SECURE email to ECM@scfhp.com or fax to **1-408-874-1469.** Allow up to 5 business days for referral to be reviewed once received.

Patient/Member Information	
First Name:	Last Name:
DOB:	SCFHP ID:
Spoken Language:	Phone:
Current Address:	
Name/Agency Referral Information	
Referred by Name/Agency:	
Is referring agency a SCFHP ECM Provider? ☐ Yes or ☐ No	
Address:	
Phone:	Email:
ECM Provider recommendation (Optional):	

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

1. Is **not** enrolled in a program or service included in the ECM Exclusions below:

- 1915(c) waivers: Multipurpose Senior Services Program (MSSP)
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternatives (HCBA) Waiver
- HIV/AIDS Waiver
- HCBS Waiver for Individuals with Developmental Disabilities (DD)
- Self-Determination Program for Individuals with I/DD.
- Cal MediConnect (CMC)
- Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- Program for All-Inclusive Care for the Elderly (PACE)
- Family Mosaic Project Services
- California Community Transitions (CCT) Money Follows the Person (MFTP)
- Basic or Complex Case Management
- Hospice

2. Can check the box next to one of the following ECM Populations of Focus:
☐ **Population #1 | Individuals and Families Experiencing Homelessness** Must meet all of the following criteria: ☐ Experiencing homelessness ☐ AND inability to successfully self-manage at least one complex physical, behavioral or developmental health need ☐ **Population #2 | Adult High Utilizers** Must meet at least one of the following criteria: ☐ Visited the emergency department 5 or more times within a 6-month period that could have been avoided ☐ AND/OR have 3 or more unplanned hospital and/or short-term skilled nursing facility stays in a 6-month period ☐ **Population #3 | Adult SMI and SUD** Must meet all of the following criteria: ☐ Meet the eligibility criteria for participation in or obtaining services through the County Specialty Mental Health (SMH) System AND/OR the Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program. ☐ AND actively experiencing at least one complex social factor influencing their health ☐ AND meet one or more of the following criteria: ☐ Are at high risk for institutionalization, overdose and/or suicide ☐ Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care ☐ Visited the emergency department or was hospitalized 2 or more times due to SMI or SUD in the past 12 months ☐ Pregnant or post-partum (12 months from delivery)
Populations 4, 5, and 6 available 1/1/2023
☐ **Population #4 | Individuals Transitioning from Incarceration** ☐ Are transitioning from incarceration or transitioned from incarceration within the past 12 months ☐ AND have at least one of the following conditions: ☐ Chronic mental illness ☐ Substance Use Disorder (SUD) ☐ Chronic disease ☐ Intellectual or developmental disability ☐ Traumatic Brain Injury (TBI) ☐ HIV ☐ Pregnancy ☐ **Population #5 | Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services** ☐ Are eligible for Long-Term Care services who, in the absence of services and support, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) Please note: individuals must be able to live safely in the community with wraparound supports ☐ **Population #6 | Nursing Facility Residents Who Want to Transition to the Community** ☐ Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so

Supporting Documents	
The following supporting documents are recommended. Check all that apply and attach to this referral.	
☐ Face sheet ☐ Care plan ☐ Recent chart notes ☐ Other	
Referrer Signature:	Date Referral Sent:

For SCFHP Use: Source: ☐ Email ☐Fax ☐Mail ☐ In-person ☐Other Date received: