Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

COMMUNITY HEALTH WORKER (CHW) PLAN OF CARE FORM

Please return this form by fax to 1-805-248-7481 or email at HealthEducation@goldchp.org.

MEMBER INFORMATION			
Member Last Name:	First Name:	MI	Date of Birth:
Member ID Number:	Address:		City, State, Zip:
Primary Phone Number:	Secondary Phone Number:		

REFERRAL INFORMATION		
Name of Treating Physician:	Phone Number:	Fax Number:
Name of Primary Care Provider(PCP):	Phone Number:	Fax Number:

PLAN OF CARE

Please complete the Plan of Care Form for the member. **LIST THE GOALS AND OUTCOMES OF EACH SPECIFIC INTERVENTION.**

CLINICAL INFORMATION (To be completed by the treating physician or office staff.)

Provider Signature: _____ NPI Number: _____ Date: _____

Effective Date of Service: _____ End Date of Plan of Care: _____

The Plan of Care must be reviewed and updated every six months and incorporated into the member's medical record.