Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PROVIDER RECOMMENDATION - COMMUNITY HEALTH WORKER FORM

To refer your patient to a community health worker, please return this form by fax to 1-805-248-7481 or email HealthEducation@goldchp.org. This form is for Gold Coast Health Plan members only.

Please check one of the following: ☐ Under 12 Units of Service ☐ Over 12 Units of Services (attach Plan of Care Form)

Section 1: Referring person information

Referral date:	Name and title of referring person:	Clinic / Agency:
Email address:	Phone number:	Fax number:

Section 2: Member information

Name: (First name) (Last name)		Parent / caregiver / guardian name (if minor):
Member ID:	Date of birth:	Primary phone:
Primary language:		Alternate phone:

Alternate contact person name: _____

Phone number: _____

Relationship: _____

Does the member have primary Medi-Cal coverage?: ☐ Yes ☐ No (explain): _____

Is the member / caregiver / guardian aware of the referral to a community health worker? ☐ Yes ☐ No

Is the member receiving support from another organization? ☐ Yes ☐ No

▸ *If yes, provide the worker's name / contact information / organization:* _____

Section 3: Reason for CHW Services

☐ Counseling / social support services: _____

☐ Need support with dental health / dentist: _____

☐ Need support with access to the vision plan: _____

☐ Need support with health care: _____

☐ Need support with scheduling medical appointments: _____

☐ Need assistance with durable medical equipment issue: _____

☐ Need support with social determinants of health (housing assistance, food insecurity, transportation, community-based resources, phone service, employment, education, caregiver support, financial assistance): _____

_____

☐ ACE Screening: _____

☐ Violence Prevention: _____

☐ Other assistance: _____

If you have any questions, contact the Health Education Department at 1-805-437-5624.