Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

MEMBER INFORMATION
Please print or type

Last Name: _____ First Name: _____ Date: _____

Mailing Address: _____ City: _____ Zip: _____

Medi-Cal ID: _____ Phone: _____ Birth Date: _____

Language Preference: ☐ English ☐ Spanish ☐ Other: _____

REFERRAL SOURCE INFORMATION

Last Name: _____ First Name: _____

Mailing Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

RELATION TO MEMBER: ☐ Self ☐ Parent / Guardian ☐ Family / Friend ☐ Primary Care Provider (PCP) ☐ ECM Provider ☐ Other Service Provider ☐ GCHP Staff ☐ Community Based Organization (CBO)

PREFERRED CONTACT METHOD: ☐ Email ☐ Phone ☐ Mail

REFERRING ORGANIZATION (if applicable):

HAS MEMBER BEEN INFORMED THAT A REFERRAL WAS BEING SUBMITTED? ☐ Yes ☐ No

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

All Ages:

☐ Homeless or at risk of becoming homeless.
- Staying outside, in a car, in a tent, in an overnight shelter, temporarily in someone else's home (i.e., couch-surfing).
- Fleeing domestic violence.
- Leaving residential program, jail, hospital, or other institution without housing.
- Losing housing within 30 days.

☐ Has been incarcerated within the last year.

Adults (18+):

☐ Serious mental illness
☐ Substance use disorder
☐ 5+ ER visits in six months
☐ 3+ unscheduled hospital or nursing facility stays in six months

REASON FOR REFERRAL

What is your concern?	
Desired outcome or result:	
Additional Information:	