



Child/Youth Enhanced Care Management (ECM) Referral Form

Email: CCHPCalAIMReferrals@cchealth.org

Return completed referral form and all applicable documentation via **SECURE** email to CCHPCalAIMReferrals@cchealth.org. Allow up to 5 business days for referral to be reviewed once received. Referrals can also be completed and submitted via the CCHP Provider Portal. Questions? Please call our CalAIM Unit at 925-313-6887 (TTY 711).

- ECM is a statewide Medi-Cal Managed Care Plan (MCP) benefit to support comprehensive care management for Members with complex needs.
- DHCS' vision for ECM is to coordinate all care for eligible Members, including across the physical, behavioral, and dental health delivery systems.
- ECM is interdisciplinary, high-touch, person-centered, and provided primarily through in-person interactions with Members where they live, seek care, or prefer to access services.
- ECM is the highest tier of care management for Medi-Cal MCP Members.
- CCHP prefers referrals to be completed and submitted via the CCHP Provider Portal. This referral form is for providers who do not have access to our CCHP Provider Portal.

1. MEMBER INFORMATION *Asterisk (*) indicates required information.*

*Date of Referral:	
*Type of Referral:	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent
*Member's Managed Care Plan:	
*Member First Name:	
*Member Last Name:	
Member Medi-Cal Client Index Number (CIN):	
Managed Care Plan Member ID Number:	
*Member Date of Birth (MM/DD/YYYY):	
*Member Primary Phone Number:	
Member Preferred Language:	
Member Primary Care Provider Name:	
*Member Residential Address:	<input type="checkbox"/> Please check here for: No fixed current address. If available, please list frequently visited location for the Member.
*Member Residential City:	
Member Residential Zip Code:	

1. MEMBER INFORMATION *Asterisk (*) indicates required information.*

Member Email:	
Best Contact Method for Member / Caregiver, if applicable:	<input type="checkbox"/> Phone <input type="checkbox"/> Email
Best Contact Time for Member/Caregiver:	
Parent/Guardian/Caregiver Name, if applicable:	
Parent/Guardian/Caregiver Phone Number, if applicable:	
Parent/Guardian/Caregiver Email, if applicable:	

2. REFERRAL SOURCE INFORMATION *Asterisk (*) indicates required information.*

*Referring Organization Name:	
Referring Organization National Provider Identifier (NPI):	
*Referring Individual Name:	
Referring Individual Title:	
*Referring Individual Phone Number:	
*Referring Individual Address:	
*Referring Individual Email Address:	
*Referring Individual Relationship to Member:	<input type="checkbox"/> Medical Provider <input type="checkbox"/> Social Services Provider <input type="checkbox"/> Other Please provide additional detail in Section 5 – Additional Comments.

**COMMUNITY PARTNERS
(NON-ECM PROVIDERS) ONLY**

Does the Member have a preferred ECM Provider?
Please select one of the following:

- ☐ Yes, this Member has a preferred ECM Provider.

Preferred ECM Care Manager:

Preferred ECM Provider Organization:

- ☐ No, this Member does not have a preferred ECM Provider.

ECM PROVIDERS ONLY

Does the referring organization recommend that the Member be assigned to it as their ECM Provider?

Please select one of the following:

- ☐ Yes, our organization should be the Member's ECM Provider.
- ☐ No, our organization recommends this Member is assigned to a different ECM Provider based on their needs.

Please provide additional detail in Section 5 – Additional Comments.

- ☐ No, this Member wants an alternative preferred ECM Provider.

Preferred ECM Care Manager:

Preferred ECM Provider Organization:

ECM PROVIDERS WITH PRESUMPTIVE AUTHORIZATION ONLY

Does the Member have an ECM Benefit Start Date?

Please select one of the following:

- ☐ Yes, this Member has an ECM Benefit Start Date

ECM Benefit Start Date (MM/DD/YYYY):

- ☐ No, this Member does not have an ECM Benefit Start Date

ECM Benefit Start Date is the date when billable ECM services were first provided to the Member. This does not include outreach services.

3. MEMBER ECM ELIGIBILITY BY POPULATION OF FOCUS

CHILDREN/YOUTH (UNDER 21) ECM ELIGIBILITY OR HOMELESS FAMILIES – CHECK ALL THAT APPLY

If the Member being referred is a child, youth, or family (homelessness), please review each indicator and indicate yes to all those that apply across the child/youth Population of Focus definitions, to help the MCP determine whether the individual qualifies for ECM and understand the child/youth/family's needs as fully as possible. Please leave blank all indicators that do not apply, to the extent of your knowledge.

If you are referring a child/youth who is experiencing homelessness, and their family members or caretakers are also experiencing homelessness and have coverage through Medi-Cal Managed Care, please consider referring all family members/caregivers for ECM services. MCPs are encouraged to work with ECM Providers to serve a family unit together when referred for experiencing homelessness.

- ☐ **HOMELESSNESS: Homeless families or Unaccompanied Children/Youth Experiencing Homelessness**

Please confirm the Member meets at least one of the following criteria:

- ☐ Child/youth or family with Members under 21 years of age, who is experiencing homelessness (unhoused, in a shelter, losing housing in next 30 days, exiting an institution to homelessness, or fleeing interpersonal violence)
AND/OR
- ☐ 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 shelter; or is abandoned in hospital (in hospital without a safe place to be discharged to)

- ☐ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT UTILIZATION: Children and Youth at Risk for Avoidable Hospital or ED Utilization**

Please confirm the Member meets at least one of the following criteria in the last 12 months:

- ☐ Child/youth has 3 or more emergency room visits that could have been avoided with appropriate care within the last 12 months;
AND/OR
- ☐ 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.

- ☐ **SERIOUS MENTAL HEALTH/SUBSTANCE USE: Children and Youth with Serious Mental Health and/or Substance Use Disorder (SUD) Needs**

Please confirm the Member meets eligibility criteria for and/or is obtaining services through at least one of the following:

- ☐ Specialty Mental Health Services (SMHS) delivered by Mental Health Professionals (MHPs): Members under age 21 qualify to receive all medically necessary SMHS services.
- ☐ Drug Medi-Cal Organization Delivery System (DMH-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.

☐ **JUSTICE INVOLVED: Children/Youth Transitioning from a Youth Correctional Facility**

Please confirm Member meets the following criteria:

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

☐ **CCS OR CCS WHOLE CHILD MODEL: Children/Youth Enrolled in California Children's Services (CCS) or CCS WCM with Additional Needs Beyond the CCS Condition**

Please confirm the Member meets all the following criteria:

- ☐ Member is enrolled in CCS or CCS WCM.

AND

- ☐ Member is actively experiencing at least one complex social or environmental 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.

☐ **FOSTER CARE: Children/Youth Involved in Child Welfare**

Please confirm the Member meets at least one of the following criteria:

- ☐ Member is under age 21 and is currently receiving foster care in California;

AND/OR

- ☐ Member is under age 21 and previously received foster care in California or another state within the last 12 months;

AND/OR

- ☐ 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

AND/OR

- ☐ Member is under 18 and is eligible for and/or in California's Adoption Assistance Program

AND/OR

- ☐ Member is under age 18 and is currently receiving or has received services from California's Family Maintenance program within the last 12 months.

☐ **BIRTH EQUITY: Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes**

Please confirm the Member meets 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. As of 2024, Black, American Indian or Alaska Native, and Pacific Islander Members are included in this definition (referring individuals should prioritize Member self-identification)

4. ENROLLMENT IN OTHER PROGRAMS AND SERVICES (OPTIONAL)

Please use the **optional** table below to indicate other programs and services that the member is receiving under Medi-Cal. Some Medi-Cal services may require coordination with ECM. Because other Medi-Cal services may offer support similar to ECM, Members may be excluded from receiving ECM and these similar services at the same time. CCHP will review the information below and make a determination on the Member's eligibility for ECM. CCHP is responsible for determining eligibility for ECM, not the referring individual.

If there are any other care management or coordination program(s) in which the Member is enrolled, to the extent known to the referring individual, that would require coordination with ECM (such as California Children's Services, Targeted Case Management within Specialty Mental Health Services, etc.) please share additional information in Section 5 – Additional Comments. **Please leave blank all elements that do not apply to the extent of your knowledge.**

PROGRAMS	
<input type="checkbox"/> Dual Eligible Special Needs Plan (D-SNP)	<input type="checkbox"/> Hospice
<input type="checkbox"/> Fully Integrated Special Needs Plans (FIDE – SNPs)	<input type="checkbox"/> Program For All Inclusive Care for the Elderly (PACE)
<input type="checkbox"/> Multipurpose Senior Services Program (MSSP)	<input type="checkbox"/> Self-Determination Program for Individuals with I/DD
<input type="checkbox"/> Assisted Living Waiver (ALW)	<input type="checkbox"/> California Community Transitions (CCT)
<input type="checkbox"/> Home and Community-Based Alternatives (HCBA) Waiver	<input type="checkbox"/> HIV/AIDS Waiver

5. ADDITIONAL COMMENTS:

Please use this section to provide additional comments on Sections 1 and 4, as needed.

6. SUBMISSION INFORMATION & NEXT STEPS

By submitting this form, the referring individual attests to the best of their knowledge that the information in the form is correct.