CONTRA COSTA HEALTH

CONTRA COSTA HEALTH PLAN
Case Management Referral

Date: _____

CLIENT DEMOGRAPHICS		
Last Name:	First Name/MI:	☐ Male ☐ Female
CCHP Member ID:	Medical Record Number:	Date of Birth:
Street Address: City/Zip:	CCHP Member: ☐ Yes ☐ No Plan Type:	
Client Phone Numbers: Home:	Cell:	Other:
Significant Others/Relationships:		
Language: ☐ English ☐ Spanish ☐ Other:_____		
Social: ☐ Living w/Partner ☐ Lives Alone ☐ Lives w/Family/Friends ☐ Other		
Living Environment: ☐House ☐ Apt. ☐ B&C ☐ Shelter ☐ Homeless ☐ SNF ☐ Other		
Other Agency Involvement: ☐ PHN ☐ CPS ☐ Home Health ☐ Mental Health CM ☐ Other		

REFERRAL SOURCE	
Referral Source: Name: Phone Number: Fax Number: Location:	PCP Name: Phone Number: Fax Number: Location: ☐ **Same as person making referral**

Did the client give verbal consent for CCHP Case Management services? ☐ YES ☐ NO

REFERRAL TO (ONE OR MORE AS APPROPRIATE)

Case Management **Phone: 925-313-6887** **Fax: 925-252-2609**

Diagnosis:

Presenting Problem:

Goals:

Reason for referral

Care Coordination: Provides services to members who needs assistance navigating healthcare and accessing services and focuses on building natural support networks that improve independence and wellness allowing for eventual program discharge.

Select all that apply (at least 1 is required):

- ☐ Service/Benefit Coordination
- ☐ Assistance with application/access to public benefits
- ☐ Health Education
- ☐ Member Self-Referred
- ☐ BM/MH/AOD Service Coordination
- ☐ CCS to CCHP Transition Coordination
- ☐ CalAIM Assessment
- ☐ SDoH Resource Coordination
- ☐ Transportation Assistance
- ☐ Navigation of Healthcare System
- ☐ HRA/SPD/LTSS Follow-Up
- ☐ Individual Support or Advocacy
- ☐ Maternal Health Coordination “Baby Watch”
- ☐ Other (Please Specify in Comments)

Complex Case Management: Coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Member referred for:

- ☐ Transplant candidate/recipient needing coordination
- ☐ 2 or more hospitalizations in 12 months
- ☐ 15+ prescription medications
- ☐ 3 ED visits in within 12 months

Transitional Care Services: For members who are transitioning from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home or community-based settings, Community Support placements, post-acute care facilities, or long-term care (LTC) settings.

Facility Name: _____

Admission Date: _____

Anticipated Discharge Date (if known): _____