Sacramento County Enhanced Care Management (ECM) Referral Form – Children and Youth

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible Members with complex needs. The purpose of this ECM Referral is to collect key information about the Member, so that their MCP can confirm if the Member is eligible for ECM. If the Member is eligible for ECM, their MCP will assign the Member to an ECM Provider who supports the Member's specific Population(s) of Focus (POF).

To receive ECM, Medi-Cal Members must meet Department of Health Care Services (DHCS) eligibility criteria for at least one of the Populations of Focus (POF) described in the ECM Referral Form. Members can be eligible for more than one POF, so please review and complete information for all applicable POFs for a Member's age group.

ECM referrals should be submitted to the Member's Managed Care Plan by following the instructions below.

Please note, per DHCS policy, the MCP **may not** require any additional documentation (i.e. Supplemental checklists, ICD-10 codes, Treatment Authorization Request forms, etc.) to authorize ECM.

Health Plan	ECM Provider Communication Method	Community Provider (Non-ECM Provider) Communication Method
☐ Anthem Blue Cross	*Submit via Anthem Provider Website:* https://providers.anthem.com/ca *or* *secure fax: 877-734-1854 or secure email:* CalAimreferrals@anthem.com	Call Customer Care Center at **800-407-4627** (TTY 711) request "CalAIM or ECM"
☐ Health Net	*Submit via Health Net's Provider Portal provider.healthnetcalifornia.com or secure fax: 800-743-1655*	Submit via secure fax: 800-743-1655
☐ Kaiser Permanente	*If you are a contracted ECM provider with a Network Lead Entity, email the ECM referral directly to your contracted NLE:* • *Independent Living Systems (ILS): kpreferrals@ilshealth.com* • *Full Circle Health Network: referral@fullcirclehn.org*	Submit via secure email (preferred): REGMCDURNs- KPNC@kp.org with "ECM Referral" as the subject line Referral by phone: 1-833-721-6012 (TTY 711) Monday-Friday (closed major holidays) 8:30 a.m. to 5:00 p.m.
☐ Molina Healthcare of California	*Submit via secure email:* *MHC_ECM@molinahealthcare.com* *Please note underscores in email address*	Submit via secure email: MHC_ECM@molinahealthcare.com Please note underscores in email address

Please complete sections 1-6. If there is a required section that you are unable to complete, please contact the Member's Managed Care Plan above for additional support prior to submission.

1. MEMBER INFORMATION – *Asterisk (*) indicates required information.*	
Date of Referral*	
Type of Referral*	☐ Routine ☐ Expedited *Expedited Requests: Is use in instances where a provider indicates, or the MCP determines, that the standard request timeframe may seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function in accordance with APL 21-011.*
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	☐ 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	
Member Email	
Best Contact Method for Member/Caregiver, if applicable	☐ Phone ☐ 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	
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)	
Referring Individual Name*	
Referring Individual Title	
Referring Individual Phone Number*	
Referring Individual Email Address*	
Referring Individual Relationship to Member*	☐ Medical Provider ☐ Social Service Provider ☐ 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 PROVIDER 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 STREAMLINE AUTHORIZATION ONLY	**Has the Member already started ECM services?** Please select one of the following: ☐ Yes, this Member has already started ECM services ECM Benefit Start Date (MM/DD/YYYY) _____ ☐ No, this Member has not started ECM services *ECM Benefit Start Date is the date when billable ECM services were first provided to the Member. This does not include outreach services.* ***For ECM Providers serving Kaiser Permanente Members ONLY**:* *Please select your Network Lead Entity:* ☐ *Independent Living Systems* ☐ *Full Circle Health Network*

3. MEMBER ECM ELIGIBILITY BY POPUALTION OF FOCUS
CHILD AND YOUTH UNDER 21 ECM ELIGIBILITY OR HOMELESS FAMILIES – CHECK THOSE THAT APPLY
If the Member being referred is a child, youth, or a family (homelessness), please review each indicator and indicate yes to all those that apply across the child and youth Population of Focus definitions. Please leave blank all indicators that do not apply, to the extent of your knowledge. If you are referring a child or youth who is experiencing homelessness, and their family members or caretakers are also experiencing homelessness and have coverage through Medi-Cal, please consider referring all family members or caregivers for ECM services. MCPs are encouraged to work with ECM providers to serve a family unit together when referred for experiencing homelessness. Please use Section 5 – Additional Comments to note any areas where further MCP review may be warranted. For additional guidance on the ECM POF definitions, please refer to the *ECM Policy Guide*. If you are uncertain if a Member is eligible for ECM, please contact the Member's MCP using the contact information provided above.
☐ **HOMELESSNESS: Homeless families or unaccompanied children or youth experiencing homelessness**

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

☐ Child, youth, or family with members under 21 years old, who is experiencing homelessness (unhoused, in a shelter, losing housing in the 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 (for example, couch surfing) due to the 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 meet at least one of the following criteria in the last 12 months:

☐ Child or youth has three or more ED visits that could have been avoided with appropriate care within the last 12 months;

AND/OR

☐ Child or youth had two 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.

OR

☐ Is at risk for avoidable hospital or ED utilization and who would benefit from ECM but who may not meet the numerical threshold specified above. Please provide additional detail in Section 5 – Additional Comments.

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

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

☐ Specialty Mental Health Services (SMHS): members under age 21 qualify to receive all medically necessary SMHS services.

☐ Drug Medi-Cal Organization Delivery System (DMC-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 and Youth Transitioning from a Youth Correctional Facility**

Please confirm Member meets the following criteria:

☐ Member is transitioning or transitioned from a youth correctional setting within the past 12 months.

☐ **CALIFORNIA CHILDREN'S SERVICES (CCS) OR CCS WHOLE CHILD MODEL (CCS WCM): Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition**

Please confirm Member meets the following criteria:

☐ Member is enrolled in CCS or CCS WCM;

AND

☐ Member is experiencing at least one complex social 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, recent contacts with law enforcement, or crisis intervention services related to mental health, former foster youth, and/or SUD symptoms

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

Please confirm 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 has a diagnosis of at least one of the following conditions:

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 age 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 (through 12 months period).

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

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. The Managed Care Plan will review the information below and make a determination on the Member's eligibility for ECM. The Managed Care Plan 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 Care 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	
☐ Dual Eligible Special Needs Plan (D-SNP)	☐ Hospice
☐ Fully Integrated Special Needs Plans (FIDE – SNPs)	☐ Program For All Inclusive Care for the Elderly (PACE)
☐ Multipurpose Senior Services Program (MSSP)	☐ Self-Determination Program for Individuals for Individuals with I/DD
☐ Assisted Living Waiver (ALW)	☐ California Community Transitions (CCT)
☐ Home and Community-Based Alternatives (HCBA) Waiver	☐ HIV/AIDS Waiver

5. ADDITIONAL COMMENTS:	
Please use this section to provide additional comments on Section 1-4, 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. Please submit the completed ECM Referral Form to the Member's MCP via the MCP submission method above. After submission, MCPs will make an ECM authorization decision within five business days. If the Member is eligible, an ECM Provider will reach out to the Member to confirm interest in ECM and enroll in services.