KAISER PERMANENTE®

Member Referral Form

Enhanced Care Management, Complex Case Management and Community Health Workers

General referral Information

Kaiser Permanente **ONLY** accepts referrals for **Medi-Cal Members** whose coverage is assigned to Kaiser Permanente.

Kaiser Permanente employs a "No Wrong Door" approach for Enhanced Care Management (ECM), Complex Case Management (CCM), Community Health Worker (CHW), and Community Supports (CS) referrals – referrals should be submitted to the Member's Managed Care Plan (MCP) and will be accepted from all points of care within the continuum.

Which services are included in this referral form?

- Enhanced Care Management
- Complex Case Management
- Community Health Workers

Types of referrals

- **Routine:** Routine referrals are submitted for Members who do not meet the criteria for an expedited referral but have immediate needs.
- **Expedited:** Expedited referrals are submitted for Members who have immediate safety concerns or are at higher risk of being discharged from an inpatient/skilled nursing facility.

Instructions

Complete all required fields to the best of your ability and submit this form via secure email to the appropriate region. Incomplete or outdated forms may cause processing delays. The most updated referral forms can be found on the Provider Portal.

	Northern California	Southern California
Email Referrals	REGMCDURNs-KPNC@KP.org	RegCareCoordCaseMgmt@KP.org
Provider Portal	NCAL - Provider Portal	SCAL - Provider Portal

KAISER PERMANENTE

SECTION A

Fields marked with an asterisk (*) are mandatory

Is the person being referred a Kaiser Permanente (KP) Medi-Cal Member?*

☐ Yes, this is a Kaiser Permanente Medi-Cal Member

☐ No, STOP, do NOT proceed. Please send referral to their assigned Medi-Cal Managed Care Plan

Referral Source Information

Date of Referral*	**Referrer Name***
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)*	
Referrer/Referring Organization Address* (Street, City, State, Zip Code)	
Referrer Email*	**Referrer Phone Number***

Referrer Relationship to Member? Select the ONE that applies*:

☐ Medical provider ☐ Social services provider ☐ Member/family

☐ Other please specify:

External referral by? Select the ONE that applies*:

☐ Network Lead Entity (NLE)

☐ ECM, CHW or CS vendor – select the one you are affiliated with:

☐ Full Circle Health ☐ Independent Living Systems ☐ Partners in Care

☐ Foodsmart ☐ Mom's Meals

☐ Managed Care Plan (MCP)

☐ Other health care provider

☐ Mental health care provider

☐ Hospital or Emergency Room care team

☐ County or other government organization

☐ Schools/Local Education Agencies (LEAs)

☐ Other community-based provider

☐ Legal aid organizations

☐ Justice involved organizations

☐ Other, please specify:

KAISER PERMANENTE®

SECTION A

Fields marked with an asterisk (*) are mandatory

Member Information

Member Name (First Name, Middle Initial, Last Name)*	
Member Date of Birth*	**Member Phone Number***
Member Mailing Address* (Street, City, State, Zip Code)	
Member's Kaiser Permanente MRN* (or Medi-Cal CIN if MRN is unknown)	
Caregiver/Support Person Name	
Caregiver/Support Person Contact (Email/Phone Number)	

Current Service Usage

1.) Is the Member currently receiving any of the following services? Select ALL that apply:

☐ **A.) ECM –** If selected, please include the following information:

Provider Name: ______________________

Email or Phone Number: ______________________

☐ **B.) CCM**

☐ **C.) CHW**

☐ **D.) CS Services**

☐ Respite Services (Caregiver Respite)
☐ Assisted Living Facility Transitions
☐ Community or Home Transition Services
☐ Personal Care and Homemaker Services
☐ Environmental Accessibility Adaptations (Home Modifications)
☐ Medically Tailored Meals/Medically-Supportive Food
☐ Sobering Centers
☐ Asthma Remediation
☐ Housing Transition Navigation Services
☐ Housing Deposits
☐ Housing Tenancy and Sustaining Services
☐ Day Habilitation Programs
☐ Recuperative Care (Medical Respite)
☐ Short-Term Post-Hospitalization Housing
☐ Transitional Rent

Attestation*

☐ By checking this box, you confirm that all information provided on this form is accurate and has been verified. You also confirm that the Member has consented to participate in the program(s) to which they are being referred and that you can provide supporting documentation if requested.

SECTION B

☐ 1. Enhanced Care Management (Page 1 of 2)

Important Information – Please Read

Description: Enhanced Care Management (ECM) provides intensive care management services to members with complex health and/or social needs. The benefit is limited to specific Populations of Focus defined by the DHCS. ECM is available in all Kaiser Permanente's service areas.

Key Information:

- **Members may NOT be enrolled in ECM if they are receiving any of the following programs at the same time:**
  - CCM
  - CHW
  - Hospice
  - Program for All-Inclusive Care for the Elderly (PACE)
  - California Community Transitions (CCT)
  - 1915 (c) Home and Community-Based Services (HCBS) Waivers* including:
    - Medi-Cal Waiver Program (HIV/AIDS)
    - Home and Community-Based Alternatives (HCBA)
    - Assisted Living Waiver (ALW)
    - Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD)
    - Multipurpose Senior Services Program (MSSP)
    - Self-Determination Program (ICF/DD)
    - HCBS Waiver for I/DD

*Please see the DHCS website for more information on these waivers

1.1) IS THIS A STREAMLINED (PRESUMPTIVE) AUTHORIZATION REQUEST?

Question 1.1 - To be completed by the Network Lead Entities ONLY

☐ No

☐ Yes; If selected, please include the information.

Provider Name:

Lead Care Manager Name:

Service Start Date:

1.2) TYPE OF REFERRAL:

☐ Routine (5 Business Days)

☐ Expedited (3 Business Days)

SECTION B

☐ 1. Enhanced Care Management (Page 2 of 2)

1.3) IS THE MEMBER TRANSITIONING FROM ECM WITH ANOTHER CA MEDI-CAL HEALTH PLAN?

- ☐ No
- ☐ Yes; if yes selected, please complete the information.

Provider Name:

1.4) SELECT ALL QUALIFYING CRITERIA:

- ☐ Individuals without Dependent Children Experiencing Homelessness
- ☐ Families Experiencing Homelessness or Unaccompanied Children or Youth Experiencing Homelessness
- ☐ Individual at risk for avoidable hospital and/or ED Utilization
- ☐ Individual with serious mental illness (SMI) and/or substance use disorder (SUD) needs
- ☐ Individual transitioning from incarceration or who have transitioned within the last 12 months
- ☐ Adults living in the community and at risk for long-term care (LTC) institutionalization
- ☐ Adult nursing facility resident transitioning to the community
- ☐ Children and youth enrolled in California Children's Services (CCS) or CCS whole child model (WCM) with additional needs beyond the CCS condition
- ☐ Child and youth involved in Child Welfare
- ☐ Birth Equity (Individuals who is pregnant or 12 or less months postpartum)

COMMENTS (optional)

☐ 2. Complex Case Management (Page 1 of 2)

Important Information – Please Read

Description: Complex Case Management (CCM) provides extra support to avoid adverse outcomes for Members who are not enrolled in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs.

Key Information:

- A Member cannot be enrolled in CCM and ECM. Please **ONLY** select **ONE** of these services.

CCM Referral Decision Guidance

CONDITION		ACTION
No Medi-Cal coverage	➢	Refer Member to KP Community Support Hub (formerly Thrive Local) or KP Social Services department
Medi-Cal coverage not assigned to KP	➢	Refer Member to assigned Medi-Cal Health Plan
Enrolled in other KP Case Management Program providing duplicative comprehensive case management functions	➢	Consult with KP Case Management Program provider
Enrolled in Hospice	➢	Consult with Hospice
Enrolled in PACE program	➢	Consult with PACE provider

2.1) TYPE OF REFERRAL

→ Select the one that applies:

- ☐ Routine (5 Business Days)
- ☐ Expedited (3 Business Days)

2.2) TO BE ELIGIBLE, THE MEMBER MUST MEET AT LEAST ONE OF THE FOLLOWING CRITERIA.

→ Select all that apply:

- ☐ Multiple chronic conditions or one complex condition
- ☐ Significant deficits in social determinant of health that impact their health
- ☐ Difficulty navigating the health care system
- ☐ Difficulty managing treatment prescribed by their provider or nonadherence to treatment plans
- ☐ Frequent missed appointments with serious medical conditions
- ☐ Pattern of utilizing emergency services in lieu of primary or urgent care

2.3) WHAT CCM SERVICES ARE NEEDED?

→ Select the one that applies:

- ☐ **A)** Comprehensive assessment of rising risk conditions, available benefits, and resources
- ☐ **B)** Care Coordination focused on longer term Chronic Conditions
- ☐ **C)** Interventions for episodic, temporary needs

SECTION B

☐ 2. Complex Case Management (Page 2 of 2)

Comments (optional)

☐ 3. Community Health Workers (Page 1 of 2)

Important Information – Please Read

Description: Community Health Workers (CHW) are non-licensed peer advocates based in the Member's own community who **help Members reach a short-term, health-related goal**. They provide face-to-face, non-clinical, culturally appropriate peer support. **Services include health education, health navigation, peer advocacy, and assessments/applications for government assistance programs.**

Key Information:

- Eligibility for CHW services is broad and inclusive, so most KP Medi-Cal Members may qualify.
- If a Member is high risk and has more complex needs, consider whether a referral to ECM may be more appropriate to support them. **A Member cannot be enrolled in CHW if they are already enrolled in ECM.** See page 4 to learn more.
- **CHWs provide a broad range of services to support Members towards their health goals. Here are some examples of CHW services:**
  - High Risk Pregnancy Peer Support (e.g., education on lifestyle adjustments to prevent complications)
  - Diabetes Management Peer Support (e.g., education and guidance on medication adherence)
  - Substance Use Peer Support (e.g., education about substance abuse, reducing enabling behaviors, and coping strategies)

3.1) *To be completed by the Network Lead Entities (NLE) ONLY*

☐ **Check this box if a CHW has already begun providing CHW services to the Member for the goals identified in 3.2 using the standing statewide recommendation.**

Specify the NLE providing these CHW services while pending KP verification of Member eligibility

Provider (NLE) Name:

Service Start Date:

**** NOTICE:***
NLEs acknowledge that KP may deny payment for CHW services rendered to members who do not meet CHW eligibility and enrollment requirements as defined by DHCS. Per DHCS guidance, NLEs are advised to check member eligibility and enrollment in KP Medi-Cal for the month of service prior to initiating services.

KAISER PERMANENTE®

SECTION B

☐ 3. Community Health Workers (Page 2 of 2)

3.2) WHAT HEALTH-RELATED GOAL DOES THE MEMBER REQUEST CHW SUPPORT WITH?

→ Select all that apply:

☐ **A.)** In-person education, navigation, or peer advocacy (e.g., education on how to navigate the health system or self-advocate in a health care setting). **Must specify goal below:**

☐ **B.)** Help enrolling in government assistance programs (e.g., WIC, CalFresh, SSDI/SSI) to improve health. **Must specify goal below:**

☐ **C.)** Culturally appropriate health education or health navigation (e.g., education on how to shop for healthy meals, asthma prevention). **Must specify goal below:**

☐ **D.)** Outreach services to engage Member in their care plans (e.g., attending appointments with Member, helping to meet care plan goals). **Must specify goal below:**

☐ **E.)** Other: **Must specify goal below:**

COMMENTS (optional)

Any other information to assist with CHW care planning, such as the member's identified Social Determinant of Health (SDOH) need or other medical, social, or mental health barriers that the CHW can help address.

KAISER PERMANENTE®

STOP!
PLEASE READ BEFORE SUBMITTING

Complete all required fields to the best of your ability and submit this form via secure email to the appropriate region. Incomplete or outdated forms may cause processing delays. The most updated referral forms can be found on the Provider Portal.

	Northern California	Southern California
Email Referrals	REGMCDURNs-KPNC@KP.org	RegCareCoordCaseMgmt@KP.org
Provider Portal	NCAL - Provider Portal	SCAL - Provider Portal