LA County Enhanced Care Management (ECM) Benefit Referral Form – CHILD & 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.

To receive ECM, Medi-Cal Members must meet 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 instruction 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 Portal:* https://providers.anthem.com *or* *secure fax: 844-429-9626 or secure email:* CalAimreferrals@anthem.com	Call Customer Care Center at 888-285-7801 (TTY 711) request "CalAIM or ECM"
☐ Blue Shield Promise Health Plan	*Submit via SFTP*	*Submit via secure email:* ECM@blueshieldca.com
☐ 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	*Submit via secure email:* RegCareCoordCaseMgmt@KP.org *with "ECM Referral" as the subject line*	*Submit via secure email:* RegCareCoordCaseMgmt@KP.org *with "ECM Referral" as the subject line*
☐ L.A. Care Health Plan	*Submit via L.A. Care's Provider Portal:* https://www.lacare.org/ If you are a first-time user of the Provider Portal, please reach out to your Account Manager for access.	*Submit via secure fax:* (213) 438-5694 *or via secure email:* ECMMembership@lacare.org
☐ Molina Healthcare of California	*For Questions:* MHC_ECM@Molinahealthcare.com *Please note underscores in email address*	*For Referrals:* MHC_ECMReferrals@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 Frist 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.**
	Does the Member have a preferred ECM Provider? Please select one of the following:

COMMUNITY PARTNERS (NON-ECM PROVIDERS) ONLY	☐ 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 PRESUMPTIVE 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.*

3. MEMBER ECM ELIGIBILITY BY POPUALTION 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 Populations 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.

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/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. **OR** ☐ Is at risk for avoidable hospital or emergency room (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 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 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 the Member meets the following criteria: ☐ Member is transitioning/transitioned from a youth correctional setting within the last 12 month
☐ **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 of 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; 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 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 Wavier (ALW)	☐ California Community Transitions (CCT)
☐ Home and Community-Based Alternatives (HCBA) Wavier	☐ 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.