



APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE

CASCADE SELECT

Care Management Referral Form

Date: ____ / ____ / ____

Member Information

Member Name: _____

DOB: ____ / ____ / ____

Telephone Number: _____

Member ID or Provider One ID:

Preferred Language: _____

Referral Source Information

Printed Name of Person Requesting: _____

Email address: _____

Printed Name of Referring Provider (if not the same as the Requestor): _____

Phone Number: (____) _____

Fax Number: (____) _____

Clinic Name of Referring Provider: _____

TIN or NPI of Referring Provider (optional): _____

Care Management Programs—see reverse for further information

- Case Management – Assists members with multiple chronic medical and/or behavioral conditions and/or frequent use of ER/hospital.
- Health Coaching – Assists members at risk for or with adult and pediatric asthma, congestive heart failure, diabetes, and COPD.
- Transition of Care – Assists members transitioning between care settings.
- Community Programs – Coordinates care and services for members requiring assistance with community-based resources.

Medical – Member with:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn’s Disease | <input type="checkbox"/> High Healthcare Cost | <input type="checkbox"/> Parkinson’s Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> CVA | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ventilator Dependency |
| <input type="checkbox"/> COPD | <input type="checkbox"/> ESRD/Dialysis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoarthritis | |

Behavioral – Member diagnosed with:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Major depression |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Psychosis/Psychiatric disorder | <input type="checkbox"/> Mood disorders |
| <input type="checkbox"/> Chemical dependency/Substance abuse | <input type="checkbox"/> Impulse control disorder | <input type="checkbox"/> Other _____ |

OB

Current gestational age: ____ weeks High risk OB

Social – Needs assistance with:

- | | | | |
|--|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Bill paying | <input type="checkbox"/> Child Care | <input type="checkbox"/> Food bank | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Caregiver respite | <input type="checkbox"/> Elder Care | <input type="checkbox"/> Housing | <input type="checkbox"/> Employment assistance |

SSI/SSDI Benefits

- Assist member with applying for disability benefits through SSI/SSDI



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Care Management Referrals

We offer free programs to Community Health Plan of Washington (CHPW) and Community Health Network of Washington (CHNW) members with complex health conditions. As a provider, you play an important role in connecting members with these valuable services. The following Care Management programs are offered to assist our members:

Case Management

Assists members with multiple chronic conditions and/ or frequent use of the emergency room and/or hospital. Our case managers coordinate care, manage transitions between levels of care, and work collaboratively with all providers to identify the best care plan possible. Areas of focus include addressing member's physical and psychosocial barriers to health condition improvement, medication compliance, and member goals resulting in decreased emergency room and hospital utilization.

Transition of Care

Assists members to ensure care is uninterrupted when moving between care settings or to the home. Care settings may include hospitals, mental health facilities, substance use treatment facilities, skilled nursing facilities, long-term care facilities, rehabilitation facilities, and correctional facilities. Areas of focus include coordination of services, reviewing discharge plans, and possibly connecting members to longer-term care management programs.

Health Coaching

Helps members at risk for or diagnosed with adult and pediatric asthma, diabetes, and COPD. Health Coaches provide education, coaching, and support to members to help them understand and manage their conditions.

Community Programs

Assists members by addressing social determinants that have an impact on member health. Provides care coordination and referral services to members.