COMMUNITY HEALTH PLAN of Washington™
The power of community

Apple Health (Medicaid)
Medicare Advantage
Individual & Family Plans

Care Management Referral Form

Date: ___/___/____ Line of Business:_____

Member Information

Member Name: _____ DOB: ___/___/_____
Phone Number: _____ Member ID or Provider One ID:_____
Preferred Contact Day or Time:_____ Preferred Language:_____

Referral Source Information

Name of Person Requesting:_____ Email Address: _____
Name of Referring Provider (if not the same as requestor):_____
Phone Number:_____ Fax Number:_____
Clinical Name of Referring Provider: _____
TIN or NPI of Referring Provider (optional):_____

Care Management Programs – see next page for further details on programs.

☐ **Case Management** - Assists members with chronic medical and/or behavioral conditions and/or frequent use of ER/hospital. Including case management and care coordination.

☐ **Diabetes Care Program** - Assist members with diabetes in self-management strategies through health coaching and/or case management.

☐ **Complex Discharge** - Assist members with complex discharge needs and transition between care settings.

☐ **Complex Case Management** - Assists members with complex medical and/or behavioral health needs, complex social needs, and personal barriers to health compliance.

☐ **Community Support Services** - Coordinate services for members requiring assistance with community-based resources and social drivers of health.

☐ **Healthy You, Healthy Baby Program** - Individualized support before, during, and after pregnancy.

Please provide details on what events, conditions, or needs the member is needing assistance or coordination with:

Medical Conditions: _____

_____

_____

☐Member Receiving Dialysis Dialysis Start Date: _____ Dialysis Center:_____

Behavioral Health Conditions: _____

_____

_____

Social Needs:

☐Bill Paying ☐Elder Care ☐Housing
☐Caregiver Respite ☐Employment Assistance ☐SSI/SSDI Applications
☐Child Care ☐Food Assistance ☐Transportation
☐Other:_____

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Please send the completed form by fax to 206-652-7073 or email to CareMgmtReferrals@chpw.org

Care Management Program Referrals

We offer free programs to Community Health Plan of Washington (CHPW) members with various needs. 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.

Complex Case Management

The Complex Case Management program is designed to provide intensive, personalized case management for members who require various resources to manage their health and improve their quality of life. Complex Case Management assists members with multiple complex needs, including clinical, social, and personal barriers to health compliance.

Complex Discharge

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.

Diabetes Care Program

Curated for members with a diagnosis of diabetes or pre-diabetes. The Diabetes Care Program provides health coaching and case management services focusing on building the member's foundations for self-management of their diabetes. Throughout the program, health coaches and case managers provide education, coaching, and support to members to help them understand and manage their health and lifestyle choices.

Community Support Services

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

Healthy You, Healthy Baby Program

This program can help members understand the health care system so they can set their own health goals and make the right choices for them. Our team of OB, NICU, and Pediatric case managers provide individualized support before, during, and after pregnancy, and members will learn about pregnancy milestones and what to expect, and also learn about benefits and services for baby.