L.A. County Health Homes Program (HHP) Member Referral Form

Use this form to refer a member whom you assess as HHP eligible. **Please confirm the patient's health plan and submit this completed HHP referral form to the appropriate health plan via secure email or secure fax.** Health plan will assess the submitted member's eligibility and respond with next steps or request more information within one week.

Health Plan	Secure Email Address	Secure Fax Number
☐ Anthem Blue Cross	CAHealthHomes@anthem.com	N/A; Submit secure email only
☐ Blue Shield of California Promise Health Plan	HealthHomesProgram@blueshieldca.com	
☐ Health Net	Health_Homes_Program@healthnet.com *Please note underscores in email address*	
☐ L.A. Care Health Plan	HealthHomesReferrals@lacare.org	(213) 438-5694 *Submit either secure email or fax*
☐ Molina Healthcare of California	Health_Homes_Program@Molinahealthcare.com *Please note underscores in email address*	N/A; Submit secure email only

Asterisk (*) identifies required information field on this HHP referral form

REFERRAL SOURCE INFORMATION	
Internal referring department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Other	
External referral by* (select one): ☐ Hospital ☐ PPG ☐ PCP ☐ Clinic ☐ Other	
Referring Individual Name:*	
Referring Organization Name:*	
Referrer Phone Number:*	( )
Referrer Email Address:*	
Has the member expressed interest in enrolling in HHP?* ☐ Yes, and I have completed the HHP screening checklist for the member. ☐ No, I would like to validate HHP eligibility prior to discussing HHP with the member.	
Is the member currently being followed by a health plan case manager or part of an external case management program? ☐ Yes ☐ No ☐ Unknown If yes, please provide contact information as available:	
Is the member experiencing any housing insecurities/homelessness?* ☐ Yes ☐ No If yes, please explain:	

MEMBER INFORMATION			
Member Name:*			
Member's Medi-Cal Client ID #*		Member Date of Birth:*	
Member Address:			
Member Primary Phone Number:*	( )	Best Time to Contact:	
Member's Preferred Language:*			
Caregiver's Name:		Caregiver's Alternate Phone Number *(if available)*:	( )

MEDI-CAL ELIGIBILITY:*	Member in Medi-Cal managed care? *Please check Automated Eligibility Verification System (AEVS)*: ☐ Yes ☐ No
	Member in Cal MediConnect? ☐ Yes ☐ No If yes, member is **NOT** eligible for HHP

DIAGNOSIS*: Please check **all** that apply. For a patient to be eligible for the HHP, they must meet at least one chronic condition **AND** one acuity criteria. Please indicate which chronic condition criteria **AND** which acuity criteria this patient meets.

Chronic Condition Criteria

AND

Member has **at least one** chronic condition in the following categories *(check all that apply)*:

1. ☐ Has at least two of the following: ***OR***
   - ☐ chronic obstructive pulmonary disease
   - ☐ chronic renal (kidney) disease
   - ☐ diabetes
   - ☐ traumatic brain injury
   - ☐ chronic or congestive heart failure
   - ☐ coronary artery disease
   - ☐ chronic liver disease
   - ☐ dementia
   - ☐ substance use disorders
2. ☐ Hypertension and one of the following: ***OR***
   - ☐ chronic obstructive pulmonary disease
   - ☐ diabetes
   - ☐ coronary artery disease
   - ☐ chronic or congestive heart failure
3. ☐ Has one of the following: ***OR***
   (Eligible for the HHP starting 1/1/2020)
   - ☐ major depression disorders
   - ☐ bipolar disorder
   - ☐ psychotic disorders, including schizophrenia
4. ☐ Asthma

Acuity Criteria

Member has **at least one** acuity/complexity criteria:

☐ Has at least three or more of the Health Homes Program-eligible chronic conditions; ***OR***

☐ Has had at least one inpatient stay in the last 12 months
If checked, provide date of last inpatient stay:
_____________ (MM/DD/YYYY); ***OR***

☐ Has had three or more emergency department (ED) visits in the last 12 months
If checked, provide date of last ED visit:
_____________ (MM/DD/YYYY); ***OR***

☐ Chronic homelessness**

***For Health Homes, a chronically homeless individual means a person with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or who has had at least four episodes of homelessness in the past three years. Any of the Health Homes chronic conditions qualify as a condition limiting activities of daily living.*

An individual who is currently residing in transitional housing, or who has been residing in permanent supportive housing for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her residence. For Health Homes eligibility, individuals can meet either the HUD chronically homeless definition or the AB 361 definition.

Additional comments, if any:

REVISED DRAFT 12/11/2019