

Care Coordination Transitions of Care (RAE to RAE) Referral Form

Please use this form when referring Health First Colorado (Colorado's Medicaid Program) Members transitioning between RAEs for care coordination services. **Please follow-up/respond to the referring RAE within 2 business days of receiving this referral.**

REFERRING FROM	
Referring RAE: Choose a RAE	Referral date:
Person Referring: (name/number/email)	Referring RAE-Lead Care Coordinator (name/number/email):
RAE Receiving Referral: Choose A RAE	Receiving RAE contact info Choose an email

MEMBER INFORMATION	
Member Name:	Member DOB:
Member Phone:	Health First Colorado ID#:
Member Address:	Member Email Address:
Primary Language:	
COUP? If yes, are they locked-in?	COMPLEX?
Previous Primary Care Medical Provider: (old RAE)	New Primary Care Medical Provider: (new RAE)
Alternate Contact – Parent/Guardian or Other Family Member/Caretaker (if applicable)	
Alternate Contact Name:	Alternate Contact Phone:
Relationship to Member:	
Member has consented to contact and exchange information with this person: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Care Coordination Needs (check all that apply and elaborate for any box checked)	
<input type="checkbox"/> Multiple chronic medical conditions	<input type="checkbox"/> Full-benefit Medicare-Medicaid enrollee
<input type="checkbox"/> Behavioral health and/or substance use issues	<input type="checkbox"/> Multiple unmet social needs
<input type="checkbox"/> New chronic condition	<input type="checkbox"/> Inadequate support system
<input type="checkbox"/> Non-adherence to treatment plan	<input type="checkbox"/> Difficulty accessing/applying for benefits
<input type="checkbox"/> Due for well-child visit	<input type="checkbox"/> Foster care medical and/or behavioral health care coordination needs (e.g., being seen by a PCP within one week of placement)
<input type="checkbox"/> Pregnancy/postpartum support and service coordination needs	<input type="checkbox"/> Requires services of a PCP, dentist, specialist, and/or behavioral health provider

- Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.)
- Urgent Medication Needs (Rx refills)
- Other (please describe)

OTHER NOTES/CONCERNS (i.e., outstanding medical issues, SDoH needs, MH treatment or medication adherence concerns that need to be addressed ASAP)

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Systems of Care Involved with Member (check all that apply and elaborate for any box checked)

- | | |
|---|---|
| <input type="checkbox"/> Single-Entry Point (SEP) | <input type="checkbox"/> Home Health Providers |
| <input type="checkbox"/> Community Centered Boards (CCB) | <input type="checkbox"/> Private Duty Nurse (PDN) |
| <input type="checkbox"/> Department of Human Services (DHS) | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Skilled Nursing Facility (SNF) | <input type="checkbox"/> Other HCBS Waiver Provider(s) |
| <input type="checkbox"/> Residential Treatment Facility (RTC) | <input type="checkbox"/> Other Long-Term Services and Supports (LTSS) |
| <input type="checkbox"/> HCBS Care Manager | |
| <input type="checkbox"/> Behavioral/Mental Health | |

Other (please describe)

Systems of Care (elaborate for any box checked, including name entity, name of person and contact information).

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