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: ☐ Yes ☐ No		

Care Coordination Needs (check all that apply and elaborate for any box checked)

- ☐ Multiple chronic medical conditions
- ☐ Behavioral health and/or substance use issues
- ☐ New chronic condition
- ☐ Non-adherence to treatment plan
- ☐ Due for well-child visit
- ☐ Pregnancy/postpartum support and service coordination needs
- ☐ Full-benefit Medicare-Medicaid enrollee
- ☐ Multiple unmet social needs
- ☐ Inadequate support system
- ☐ Difficulty accessing/applying for benefits
- ☐ Foster care medical and/or behavioral health care coordination needs (e.g., being seen by a PCP within one week of placement)

☐ Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.)

☐ Requires services of a PCP, dentist, specialist, and/or behavioral health provider

☐ 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)

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

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

☐ Other (please describe)

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