Member Transition of Care Coordination (RAE-to-RAE) Form

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

TRANSITIONING FROM	
Current RAE: Choose a RAE	**Date:**
Contact Person: (name/number/email)	**Current RAE-Lead Care Coordinator** (name/number/email):
Receiving RAE: Choose a RAE	**Receiving RAE contact info:** Choose an email/phone #

MEMBER INFORMATION	
Member Name:	**Member DOB:**
Member Phone:	**Health First Colorado ID#:**
DOC Involvement?	**DOC #**
Member Address:	**Member Email Address:**
Primary Language:	**Interpreter Needed: Yes** ☐ **No** ☐
COUP? If yes, are they locked-in? Yes ☐ No ☐	**COMPLEX Member ($25k)?**
Previous Primary Care Medical Provider *(old RAE)*	**New Primary Care Medical Provider:** *(new RAE)*
Alternate Contact – Parent/Guardian or Other Family Member/Caregiver (if applicable)	
Alternate Contact Name:	**Alternate Contact Phone:**
Relationship to Member:	
Member has consented to contact and exchange information with this person: Yes ☐ No ☐ *Include signed Release of Information with this form.*	

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
- ☐ Full-benefit Medicare-Medicaid enrollee
- ☐ Multiple unmet social needs
- ☐ Inadequate support system
- ☐ Difficulty accessing/applying for benefits

- [ ] Pregnancy/postpartum support and service coordination needs
- [ ] Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.)
- [ ] Foster care medical and/or behavioral health care coordination needs (e.g., being seen by a PCP within one week of placement)
- [ ] Requires services of a PCP, dentist, specialist, and/or behavioral health provider
- [ ] Urgent Medication Needs (Rx refills)
- [ ] Other (please describe)
- [ ] Durable Medical Equipment (DME)

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)
- [ ] Home Health Providers
- [ ] Private Duty Nurse (PDN)
- [ ] Foster Care
  - [ ] CASA

- ☐ Residential Treatment Facility (RTC)
- ☐ Justice System
- ☐ Behavioral/Mental Health
- ☐ HCP Care Coordination
- ☐ Early Intervention/Board of Community Education Services (BOCES)
- ☐ Case Manager
- ☐ Other HCBS Waiver Provider(s)
- ☐ Other Long-Term Services and Supports (LTSS)
- ☐ School (IEP/504)
- ☐ Coordination via specialty clinics (e.g., Special Care Clinic at CHCO)
- ☐ Other/Other Community-Based Coordination (please describe)

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