



## Care Coordination Referral Form (Health First Colorado Region 6)

Please use this form when referring Health First Colorado (Colorado’s Medicaid Program) members to CCHA for care coordination services. CCHA serves members attributed to PCPs located in the following counties: Boulder, Broomfield, Clear Creek, Gilpin and Jefferson.

**To submit referral to CCHA Care Coordination:**

Please scan and email\* this completed form to R6Referral@cchacares.com or fax this completed form to 303-256-1837.

\*All emailed forms must be sent encrypted

<b>REFERRING FROM</b>	
Referring Agency/Practice:	
Person Referring:	Referral date:
Email:	Phone:

<b>MEMBER INFORMATION</b>	
Member Full Name:	Member DOB:
Member Phone:	Health First Colorado ID#:
Primary Language:	
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	

<b>REASON FOR REFERRAL (check all that apply)</b>	
<input type="checkbox"/> Multiple chronic medical conditions <input type="checkbox"/> Behavioral health and/or substance use issues <input type="checkbox"/> New chronic condition <input type="checkbox"/> Non-adherence to treatment plan <input type="checkbox"/> Due for well-child visit <input type="checkbox"/> Pregnancy/postpartum support and service coordination needs <input type="checkbox"/> Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.) <input type="checkbox"/> COUP/Lock-in Referral <input type="checkbox"/> Other (please describe)	<input type="checkbox"/> Full-benefit Medicare-Medicaid enrollee <input type="checkbox"/> Multiple unmet social needs <input type="checkbox"/> Inadequate support system <input type="checkbox"/> Difficulty accessing/applying for benefits <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"/> Requires services of a PCP, dentist, specialist, and/or behavioral health provider <input type="checkbox"/> No-show Outreach

If you have additional notes, include on the next page.

**OTHER NOTES/CONCERNS**

**Member Full Name:**

**Notes:**