Care Coordination Referral Form (Health First Colorado Region 7)

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: El Paso, Park and Teller.

To submit referral to CCHA Care Coordination:
Please scan and email* this completed form to R7Referral@cchacares.com or fax this completed form to 719-278-5475.
*All emailed forms must be sent encrypted

REFERRING FROM	
Referring Agency/Practice:	
Person Referring:	**Referral date:**
Email:	**Phone:**

MEMBER INFORMATION	
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: ☐ Yes ☐ No	

REASON FOR REFERRAL (check all that apply)

- ☐ 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
- ☐ Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.)
- ☐ COUP/Lock-in Referral
- ☐ Other (please describe)
- ☐ 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)
- ☐ Requires services of a PCP, dentist, specialist, and/or behavioral health provider
- ☐ No-show Outreach

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

OTHER NOTES/CONCERNS

Member Full Name:

Notes: