Community Health Worker (CHW) Member Referral Form
Molina Healthcare of California

Asterisk (*) identifies required information field on this CHW referral form

Member Information

Member Name: *_____ Date of Birth: * _____

Medi-Cal Client ID #: *_____

Primary Phone #: _____ Best time to contact: _____

Preferred Language: _____

Email: _____

Address: _____

If member has a caregiver, please provide their contact information:

Caregiver Name: _____ Relationship to Member: _____

Caregiver Phone #: _____ Caregiver Email: _____

Provider Information

Referred by:

- ☐ Clinical nurse specialist
- ☐ Licensed educational psychologist
- ☐ Licensed hygienist
- ☐ Licensed marriage and family therapist
- ☐ Licensed midwife
- ☐ Licensed vocational nurse
- ☐ Nurse midwife
- ☐ Nurse practitioner
- ☐ Pharmacist
- ☐ Physician
- ☐ Physician assistant
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Public health nurse
- ☐ Registered nurse
- ☐ Other:

Referring Individual Name: *_____

Referring Organization Name: *_____

Provider NPI / Provider Tax ID # (number to be submitted with claim): *_____

Phone #: * _____ Fax #:_____

Email Address:_____

Would you like to be consulted for any plan of care that is created? * ☐ Yes ☐ No

Member's Eligibility

Check all that apply to the individual: *

- ☐ Alcohol or Substance Misuse
- ☐ Any stressful life event identified through the Adverse Childhood Events screening
- ☐ Community violence exposure
- ☐ Current diagnosis of asthma with poor control
- ☐ Diagnosis of asthma
- ☐ Domestic or Intimate Partner violence
- ☐ Exposure to environmental health risks
- ☐ Individual expressed need for support in navigating the health system or coordinating resources
- ☐ Individuals who have faced a higher risk of institutionalization within the past six months
- ☐ Individuals with Intellectual or Developmental Disabilities (I/DD)
- ☐ Need for recommended preventive services [e.g., updated immunizations, annual dental visits, well-childcare visits for children}
- ☐ One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months
- ☐ One or more stays at a detoxification facility within the previous year
- ☐ One or more visits to a hospital emergency department within the previous six months
- ☐ Presence of medical indicators indicating an increased risk of chronic disease
- ☐ Social Determinant of Health need [e.g., housing, food insecurity]
- ☐ Suspected or diagnosed behavioral health condition
- ☐ Suspected or diagnosed chronic health condition
- ☐ Tobacco use
- ☐ Two or more missed medical appointments within the previous six months

Exclusionary criteria

Check all that apply to the individual: *

- ☐ Member is **not enrolled** in Enhanced Care Management

Community Health Worker Preference [optional]

Community Health Worker Name: _____

Location(s):

- ☐ Los Angeles
- ☐ Riverside
- ☐ Sacramento
- ☐ San Bernardino
- ☐ San Diego

For more information on CHW Medi-Cal Benefits, download Molina Healthcare of California CHW Medi-Cal Benefit Frequently Asked Questions (FAQs)

For Medi-Cal members:

(562) 499-6105 or email MHCCaseManagement@molinahealthcare.com

To speak with the Case Management Department: M-F 8:30 am – 5:30 pm, please call: (833) 234-1258
