



CARE COORDINATION/CASE MANAGEMENT REFERRAL

Section I to be completed by Referral Source

Molina Fax Number 866.472.4575

Customer Service Number 1-800-580-2811

Referral Date: _____

Referral Source: _____ Sender's fax #: _____ DOB: _____

Patient Name: _____ Parent Name if Child _____ SS # _____

Patient Address: _____ Patient Phone # _____

City: _____ County: _____ State: _____ Zip: _____

PCP: _____ PCP Phone # _____ Fax _____ OB Provider: _____

Reason for Referral (Be specific; this will help CC/MCM develop the Plan of Care):

Large empty box for Reason for Referral.

To be completed by MHNM CC/MCM

ISHCN _____ Yes No
Level of Risk Stratification: Low Medium High

Is this member:

Waiver enrolled? Yes No

Waiver Case Manager _____

Telephone # _____

CYFD Involved? Yes No

CYFD Case Manager _____

Telephone # _____

Targeted Case Management: Yes No

Receiving Special Education? Yes No

School _____ IEP IFSP Contact _____

Currently receiving BH Services? Yes No

If NO:

Does the member require a Mental Health Assessment? Yes No