



FAX

To: Molina Healthcare HCS Department **From:**

Fax: 1-231-668-9876 **Phone:**

Phone: 1-888-898-7969 **Pages:**

Re: Community Connector Referral **Date:**

Urgent For Review Please Reply Telephonically OR Written Report

▪ Comments:

CONFIDENTIALITY NOTICE: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.



Community Connector Referral Form

MOLINA HEALTHCARE COMMUNITY CONNECTORS:

Molina Healthcare Community Connectors are available to provide in-home visitation and assist members to navigate the care system and obtain necessary services that will adequately meet their medical needs. All Molina Healthcare members *are* eligible for the Community Connector program. Members who should be referred to a Community Connector are those actively in treatment but are failing to meet care plan milestones. If you would like to refer a Molina Healthcare member for this program, please complete this form and fax it to: **Molina Healthcare of Michigan Utilization Management Department at 1-800-594-7404.**

COMMUNITY CONNECTOR REFERRAL FORM: **Date:** _____

Referral Requestor: _____ **Requestor Contact#:** _____

Member Name: _____ **Member ID#:** _____

Member Phone# : _____ **Member Primary Language:** _____

Legal Guardian: (Name/#): _____ **PCP (Name/#):** _____

Diagnosis: _____ **Recent Hospitalization Date/s:** _____

Referral Reason: _____

Medications: _____

Current Home Health Care Services (Circle): **RN Visits** **PT/OT/ST** **IV Fluids/Meds**

Home Health Care Services Needed? Yes/No If Yes, list: _____

Current DME Use: _____ **DME Required? Yes/No If Yes, list:** _____

List any Behavioral Care Needs: _____

List Current Living Situation: _____

Caregiver Available to Assist: Yes/No? If Yes, Name/#: _____

Comments: _____

CONFIDENTIALITY NOTICE: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.