THE HEALTH PARTNERSHIP
CLIENT REFERRAL FOR CARE COORDINATION (COMMUNITY CARE TEAM) FORM

Name:	**DOB:**	**Phone:**
Address:		
Insurance: ☐Medicare ☐ Medicaid ID#Enter ID ☐ Private Insurance# Insurance Type ☐ No Insurance		
Referring Individual: Name Title:Click or tap here to enter text. Date: xx/xx/xxxx		
☐**Urgent** (Please check if patient to be contacted within 2 business days.)		
CARE COORDINATION NEEDS (check all that apply):		
☐ Questions on Medicaid ☐ Questions on Medicare ☐ Social Security ☐Long Term Medicaid ☐Respite Care ☐ Medicaid Waivers ☐ Financial Assistance ☐ Home Health ☐ Dental Needs ☐ Vision Needs ☐ Housing Needs ☐ Help finding food ☐Hospice ☐ Senior Resources/ Aging Well		
☐Accessing community resources		☐ Help connecting with Behavioral Health
	☐ Other: Click or tap here to enter text.	
REASONS FOR REFERRAL: Click or tap here to enter text.		
RELEVANT CLIENT DIAGNOSES: Click or tap here to enter text.		
MEDICATION LIST (if applicable): Click or tap here to enter text.		
COMMENTS/CONCERNS: Click or tap here to enter text.		
How can we best collaborate and communicate together to meet this member's needs? Click or tap here to enter text.		
Would you like a copy of the assessment and care coordination plan? Yes ☐ No ☐		
How often, if at all, would you like updates on the status of the care coordination plan? Click or tap here to enter text.		

What is the preferred method of communication? Phone ☐ Email ☐ Fax ☐

COMMUNITY CARE TEAM COORDINATORS

Referrals can be made by securely emailing referral form for any Coordinator in any region to referrals@ncchealthpartnership.org or by faxing to 970-761-2589

MEDICAID/NON-MEDICAID REFERRALS

Routt County (*Marissa Jaime)*	Phone: 970-819-7578	Fax: 970-761-2589
Grand/ Jackson County (*Sara Elise Bristol*)	Phone: 970-725-3477	Fax: 970-725-3478
Meeker-Rio Blanco *(Brenda Culler)*	Phone: 970-878-5112	Fax: 970-878-4315
Moffat County (*Maryanna Younger*)	Phone: 970-875-3630	Fax: 970-761-2589
Moffat County (*Michelle Peed)*	Phone: 970-875-3630	Fax: 970-761-2589

COMMUNITY CARE TEAM -NORTHWEST COLORADO COMMUNITY HEALTH PARTNERSHIP (NCCHP)
Routt- Moffat- Rio Blanco- Jackson- Grand Counties

By understanding the big picture, our care coordinators can help medical and non-medical services work together. Care Coordination can improve the overall health of patients by connecting patients with community services and resources. A care coordination program that spans all care settings can help improve transitions of care, improve treatment speed and quality of care, and improve patient satisfaction. Essential to these activities is a strong partnership between NCCHP, Rocky Mountain Health Plans, Colorado ACC Medicaid members, Colorado Department of Health Care Policy and Financing, Primary Care Medical Providers, Community resources/groups, Hospitals, Specialists, and Single Entry Point (SEP) agencies.

Examples of criteria for referrals to the Community Care Team:

- Community resource assistance such as food banks, coordination with human and social services, Social Security Disability application assistance, Medicaid application assistance, coordination with Medicaid area specialists
- Any person that is utilizing the Emergency Room or Urgent Care inappropriately, excessively, or unnecessarily
- Helping clients establish a primary care physician and get connected to health educators for unmanaged chronic illnesses such as COPD, Diabetes, High Blood Pressure/ Cardiovascular disease, Chronic Pain, Traumatic Brain Injury, etc.
- Refer and coordinate patients to mental health services for unmanaged mental health diagnosis such as Bipolar, Depression, Anxiety disorders, substance use or alcohol abuse issues

Once a client has had an initial assessment completed with a care coordinator the Community Care Team can help clients:

- Address transportation issues to Medical or Mental Health appointments
- Connect & help coordinate to community resources (food banks, housing, senior resources, etc.)
- Provide paperwork assistance regarding resources, medical or mental health services
- Provide coordination and navigation assistance with providers and services i.e. dental, eye care, hearing screens and appointments, specialty referrals
- Coordinate care and facilitate communication across systems such as behavioral health, long term care (home and community based services), specialists, etc.
- Promote self-efficacy
- Work with community resources to help clients fund and obtain hearing aids, canes, dentures, etc.

**Please note; NCCHP requires an initial intake assessment on any referrals to the Community Care Team program. This assessment helps the coordinator determine and prioritize what goals or assistance is needed. Care Coordination cannot happen until this assessment has been completed and the person agrees to care coordination. Once care plan goals are consistently being met and clients gain comfort and control in their health, the care coordinator may decrease involvement.*