ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

DDD HEALTH PLAN CARE MANAGEMENT REFERRAL

INSTRUCTIONS

Complete all applicable sections of this referral form and email it to the member's Health Plan using the corresponding email address listed below. Identify the subject line as: Care Management Referral for *(Member's Initials)*. If the referral is urgent, include the word **"URGENT"** in the subject line: **URGENT** Care Management Referral for *(Member's Initials)*. *(Refer to the DDD Health Plan Care Management Program procedure for more details.)*

MERCY CARE	UNITED HEALTHCARE COMMUNITY PLAN	TRIBAL HEALTH PROGRAM
mercycare-DDD@mercycareaz.org Phone: 602-453-8391	uhccpdd@uhc.com Phone: 800-348-4058	dddcctreferral@azdes.gov
FOR PREGNANT MEMBERS:	**FOR PREGNANT MEMBERS:**	**FOR PREGNANT MEMBERS:**
obfaxes@mercycareaz.org Phone: 602-659-9007	tracy_avant@uhc.com Phone: 602-255-8231	dddcctreferral@azdes.gov

SECTION I. MEMBER INFORMATION

Member Name *(Last, First, M.I.)*: _____ Date Submitted: _____

AHCCCS ID: _____ Date of Birth: _____ Primary Language: _____

Address *(No., Street, City, State, ZIP)*: _____

Email Address: _____ Area Code and Phone No.: _____

Responsible Person Name: _____

Email Address: _____ Area Code and Phone No.: _____

Does member have a: ☐ Public Fiduciary ☐ Court-Appointed Guardian
☐ Behavioral Health Human Rights Advocate Assigned by the Special Assistance Program

If yes, Name: _____ Area Code and Phone No.: _____

Support Coordinator Name: _____

Email Address: _____ Area Code and Phone No.: _____

Support Coordinator's Supervisor Name: _____

Email Address: _____ Area Code and Phone No.: _____

District Nurse Name, If Assigned: _____

Email Address: _____ Area Code and Phone No.: _____

Has member received Care Management services in the past from member's current Health Plan? ☐ Yes ☐ No

SECTION II. REASON FOR REFERRAL

Check all applicable care concern factors. In the Reason for Referral text box provide sufficient details needed to understand all of the care concern factors checked. Also, include information regarding the barriers to resolve the issue(s) and actions taken, such as contacts made with DDD function areas, the Health Plan, and providers to resolve the issue(s).

☐ Frequently uses the Emergency Department instead of seeing his/her providers for ongoing issues *(4 or more occurrences within past 6 months)*.

☐ Recently had multiple physical and/or behavioral health hospitalizations *(3 or more inpatient or readmissions within*

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past 6 months).

- ☐ Discharged from an inpatient or skilled facility and requires coordination of post-acute services.
- ☐ Missed 3 or more physical and/or behavioral health appointments within the past 3 months.
- ☐ Difficulty obtaining medical benefits or referrals ordered by providers.
- ☐ Diagnosed with heart failure, diabetes, asthma, chronic obstructive pulmonary disease, or depression, and requires assistance with management of the condition.
- ☐ In the process of receiving a transplant or up to one year post-transplant.
- ☐ Diagnosed with Human Immunodeficiency Virus.
- ☐ Pregnant.
- ☐ Diagnosed with a behavioral health disorder and the condition is not stable and requires assistance with management of the condition.
- ☐ May need exclusive provider restriction for overutilization of drugs with abuse potential.
- ☐ Needs or is currently receiving medication-assisted treatment for opioid use
- ☐ Social determinants of health needs are impacting member's ability to obtain the appropriate care *(e.g., basic needs not being met, safety issues in home environment, etc.)*.
- ☐ Survivor of sex trafficking.
- ☐ Recently incarcerated or is transitioning out of jail or prison within 30 days.
- ☐ Has out-of-state needs.
- ☐ Needs assistance with Tribal Nations or providers.
- ☐ A child with one or more of the following:
  - ☐ Newborn with neonatal abstinence syndrome or maternal drug exposure.
  - ☐ Child and Adolescent Level of Care Utilization System *(CALOCUS)*, level 4 or higher.
  - ☐ Serious emotional disturbance
  - ☐ Possible Children's Rehabilitation Services condition.
  - ☐ Recently removed from his/her home and placed in foster care.
- ☐ Other: _____

Reason for Referral:

SECTION III. URGENT CARE MANAGEMENT REFERRAL REQUEST

*(**Note:** Most Care Management Referrals are not urgent.)* If the referral is urgent, check the applicable urgent care concern below and provide sufficient details needed to understand why the referral is urgent.

☐ Has been in the Emergency Department for more than 24 hours with release or discharge barriers.

☐ Has medication issues which are impacting his/her daily living.

☐ Has issues with durable medical equipment which are impacting his/her daily living.

☐ Other: _____

SECTION IV. SUPPORT COORDINATOR CHECKLIST

List of documents to attach to the referral email:

☐ Completed Health Plan Care Management Referral form

☐ Current Planning Document

☐ Current Nursing Assessment, if applicable

☐ Power of Attorney, if applicable

☐ Guardianship Court Order, if applicable

EEqual Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1