

Check all that apply:

Residence Information

PCP Request

Transition Information

ENCC Referral

# Continuity of Care Referral

Prepaid Health Plan:	Eff. Date:
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Date	Client's Name (Last, First, MI)	Prime #	SSN	Medicare # Parts A <input type="checkbox"/> B <input type="checkbox"/>
DOB	Phone	Primary Language	Care Giver/Decision Maker	Phone
Case Worker Name - no load codes	Agency	Branch	Phone	Person Completing Referral Phone

## Residence Information

- Own Home     
  Homeless     
  Group Home     
  Foster Care  
 Residential Care     
  Assisted Living     
  Nursing Facility     
  In-Home Services

Facility \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Care Practitioner (PCP) Request** (1st & last name) \_\_\_\_\_

Is client currently a patient of this PCP? \_\_\_\_\_

## Transition Information: Check current supplies or services and list item and vendor.

	Item	Vendor	Need Now?
<input type="checkbox"/>	Catheter Supplies	_____	_____
<input type="checkbox"/>	Diabetic Supplies	_____	_____
<input type="checkbox"/>	Durable Medical Equipment	_____	_____
<input type="checkbox"/>	Incontinency Supplies	_____	_____
<input type="checkbox"/>	Home Health/Nursing	_____	_____
<input type="checkbox"/>	Ostomy Supplies	_____	_____
<input type="checkbox"/>	Oxygen/Suctioning	_____	_____
<input type="checkbox"/>	Tube Feeding/IV	_____	_____
<input type="checkbox"/>	Ventilator/Trach	_____	_____
<input type="checkbox"/>	Other	_____	_____

## ENCC Referral: Check primary area of concern and provide details in comments section.

- Worker requests case coordination conference with ENCC.  
 Client's health is at risk due to life-style choices that lead to non participation with care.  
 Client's health status or access to care is at risk due to emotional/behavioral problems.  
 Client's health is at risk due to language/cultural/sensory issues that create barriers to service.  
 Client's medical condition requires extensive monitoring or referrals for specialized care.

## Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Guidelines for Use and Completion of the Continuity of Care Referral (CCR) Form

**Note: The CCR form is a convenience for workers in passing pertinent information on clients to fully capitated health plans and requesting ENCC services. It is not mandatory, but can expedite services, particularly for new enrollees.**

1. Use this form to notify the fully-capitated health plan when a new or ongoing client has special needs or requires special care. **Do not complete for every client. Complete only the sections of the form that pertain to the client's needs.**
2. Use the form to advise the plan that:
  - The client is in a non-standard living arrangement, such as foster care or a nursing facility. List the name and phone number of the home or facility. **Do not complete if the person lives in his or her own home without services and has no other needs.**
  - The client would like to be assigned to a particular primary care practitioner who is on the plan's panel
  - The client has service or equipment needs that the plan will be assuming responsibility for, such as oxygen, incontinency supplies, or durable medical equipment. Indicate if there is an immediate need so the plan can arrange to transfer the order to their vendor.
  - The worker would like a call-back from the ENCC to discuss the client's needs.
  - The client has some medical care requirements, language or cultural barriers, or emotional/behavioral problems that need to be brought to the ENCC's attention.
3. Complete the form for new enrollees during enrollment counseling. Complete for ongoing clients when a significant change occurs, including moving from one type of residence to another.
4. Routing:
  - Send the white copy to the FCHP.
  - Retain the yellow copy in the case file.
  - Use the pink copy as needed (provide to client as verification of the choice of primary care practitioner, send to a mental health organization or dental care organization, etc.) or discard.
5. Fax the form to the FCHP at the same time the enrollment is put on the computer.