Community Health Worker Referral Form
Molina Healthcare of California

☐ **This referral is urgent**

Asterisk (*) identifies required information field on this CHW referral form

Medi-Cal Member information

Member Name: * _____ Date of Birth: * _____

Medi-Cal Client ID #: * _____

Primary Phone #: _____ Best time to contact: _____

Preferred Language: _____

Email: _____

Address: _____

If member has a caregiver, please provide their contact information:

Caregiver Name: _____ Relationship to Member: _____

Caregiver Phone #: _____ Caregiver Email: _____

Provider information

Referred by:

- ☐ Clinical nurse specialist
- ☐ Licensed educational psychologist
- ☐ Licensed hygienist
- ☐ Licensed marriage and family therapist
- ☐ Licensed midwife
- ☐ Licensed vocational nurse
- ☐ Nurse midwife
- ☐ Nurse practitioner
- ☐ Doula
- ☐ Pharmacist
- ☐ Physician
- ☐ Physician assistant
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Public health nurse
- ☐ Registered nurse
- ☐ ECM Provider
- ☐ Other: _____

Date of Referral: _____

Referring Individual Name: * _____

Referring Organization Name: * _____

Provider NPI / Provider Tax ID # (number to be submitted with claim): * _____

Phone #: * _____ Fax #: _____

Email Address: _____

Would you like to be consulted for any plan of care that is created? * ☐ Yes ☐ No

Member's eligibility

Check all that apply to the individual: *

- ☐ At risk for (or diagnosed) with behavioral health condition
- ☐ At risk for (or diagnosed) with a chronic health condition
- ☐ Need help controlling asthma
- ☐ Need help getting care for sexual or reproductive health
- ☐ Missed two or more medical appointments within the previous six months
- ☐ Need help navigating the health system or coordinating resources
- ☐ Experienced a stressful life event identified through the Adverse Childhood Events screening
- ☐ Experiencing domestic or intimate partner violence
- ☐ Experiencing community violence
- ☐ Has Social Determinant of Health needs [e.g., housing, food insecurity]
- ☐ At risk of institutionalization
- ☐ Has intellectual or developmental disabilities (I/DD)
- ☐ Need recommended preventive services [e.g., updated immunizations, annual dental visits, well-childcare visits for children]
- ☐ Had one or more hospital inpatient stays within the previous six months, including stays at a psychiatric facility or at risk of institutionalization
- ☐ Had one or more visits to a hospital emergency department within the previous six months
- ☐ Tobacco, alcohol or other substance misuse
- ☐ Had one or more stays at a detoxification facility within the previous year

Additional Information

Community Health Worker preference [optional]

Preferred Community Health Worker Name: _____

Preferred CHW Provider/Organization: _____

Is the member transitioning from ECM into CHW?	☐ Yes	☐ No
Has the CHW Provider already been contacted regarding services for this member?	☐ Yes	☐ No
Should this member also be considered for Case Management services?	☐ Yes	☐ No

Submit this referral form to ca_sdoh_connectors@molinahealthcare.com

Call (844) 926-6590 or email ca_sdoh_connectors@molinahealthcare to learn more about the CHW program. Click here for the CHW Benefit FAQ

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