OPTUM® Idaho Behavioral Health Plan

Field Care Coordination Referral Form

Member Information

First Name: _____ Middle Initial: _____ Last Name: _____

Medicaid ID: _____ Date of Birth: _____ Age: _____ Phone: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Region where member lives or will be returning to:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 9

Requestor Information

Requestor Name: _____ Requestor Phone Number: _____

Relationship to member:

◯ SELF

◯ Family – Relationship: _____

◯ Current Provider

Provider Type and Agency Information: _____

◯ Other – Relationship: _____

Referral Information

Is this an Urgent Referral? ◯ **YES** ◯ **NO** If YES, explain why in the Reason for Referral.

Reason for Referral for Field Care Coordination services: (1500 character max)

Is the member involved in WRAP through Children's Mental Health? ◯ YES ◯ NO

Referral Information (continued)

Current Risk Factors *(check all that apply)*:

- ☐ At risk for out-of-home placement.
- ☐ Being discharged from a hospital within 72 hours with no services in place.
- ☐ Not connected with any services.
- ☐ Involved with multiple systems related to his/her behavioral health needs.
- ☐ At least 2 inpatient hospitalizations in the past 12 months.
- ☐ In an out-of-home placement and will return home within 30 days.
- ☐ Accessing crisis centers with no behavioral health provider.
- ☐ Accessing crisis centers 3 or more times in 6 months.
- ☐ Two or more admissions to an Intensive Outpatient or Partial Hospitalization Program in one year.
- ☐ Had foster-care placements in the past 12 months.

Form Submission

Please submit via e-mail to optum.idaho.fcc@optum.com, or by fax to (888) 891-1232. Thank you.