

**LOCAL HEALTH SERVICES REQUEST FORM
INSTRUCTIONS**

PURPOSE: This form is intended for use by the Managed Care Organization [MCO] to refer clients in need of outreach and health-related services to the Local Health Department Administrative Care Coordination Unit [LHD-ACCU]. The assistance of the Local Health Department may be requested only after the MCO has made documented attempts to contact and bring into care a recipient who is difficult to reach or misses appointments. (COMAR 10.09.66.03B)

INSTRUCTIONS FOR USE:

1. **'TO'** - Fill in the appropriate Local Health Department based on the client's county of residence.
2. **'FROM'** – Indicate the referral source including contact name, address, phone number and fax number
3. **'CLIENT NAME'** – Provide client demographic information, MA number and last known address and phone number[s]
4. **'FOLLOW-UP'** – Indicate the client's population category [FOR] and the reason for the request [Related To]. Please add additional information or comments that may assist the LHD to outreach the member.

MCO Section:

- Indicate the type and number of outreach attempts (letters, phone calls, face-to-face)
- Provide the health care provider name and phone number
- Add any additional information under "Comments" that may assist the LHD to outreach the member i.e. full name and contact information of the Head of Household/Guardian; potential need for interpreter services; diagnosis/treatment; EDC; date of most recent contact between MCO and client and/or provider.
- Forward the top copy to the LHD-ACCU [LHD addresses attached]

Local Health Department Section:

- Indicate the action taken
- Include any additional case findings under "Comments" that may assist the MCO in providing on-going care coordination for the client
- Return the appropriate copy to the MCO/Provider

SELECTED DEFINITIONS:

MISSED APPOINTMENTS:

- Child under 2years who has missed two consecutive EPSDT appointments
- Child 2-21 years who has missed two consecutive appointments and is in need of treatment
- Pregnant woman who is thirty days past appointment date.
- Adult meeting 'special needs' criteria who has missed three consecutive appointments for treatment.

ADHERENCE TO PLAN OF CARE:

- Non-compliance with treatment plan or medical regime.

IMMUNIZATION DELAY:

- 60 days past immunization due date

PREVENTABLE HOSPITALIZATION:

- Inpatient care within the preceding 60 days for dehydration, pneumonia, burns, cellulitis, 'Failure to Thrive', lead poisoning, ingestion, intentional injuries

OTHER:

- Additional information that will assist the LHD with care coordination.

Date: / /
 To:
 Attention:
 Address:
 City/State/Zip:
 Phone:

HealthChoice LOCAL HEALTH SERVICES REQUEST FORM

Client Information	
Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: <input type="checkbox"/> M <input type="checkbox"/> F Hispanic: <input type="checkbox"/> Y <input type="checkbox"/> N MA#: Private Ins.: <input type="checkbox"/> No <input type="checkbox"/> Yes Martial Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Unknown If Interpreter is needed specific language:	Race: <input type="checkbox"/> African-American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one race <input type="checkbox"/> Unknown Caregiver/Emergency Contact: Relationship: Phone:
FOLLOW-UP FOR: (Check all that apply) <input type="checkbox"/> Child under 2 years of age <input type="checkbox"/> Child 2 – 21 years of age <input type="checkbox"/> Child with special health care needs <input type="checkbox"/> Pregnant EDD: ____ / ____ / ____ <input type="checkbox"/> Adults with disability(mental, physical, or developmental) <input type="checkbox"/> Substance use care needed <input type="checkbox"/> Homeless (at-risk)	RELATED TO: (Check all that apply) <input type="checkbox"/> Missed appointments: ____ #missed <input type="checkbox"/> Adherence to plan of care <input type="checkbox"/> Immunization delay <input type="checkbox"/> Preventable hospitalization <input type="checkbox"/> Transportation <input type="checkbox"/> Other:
Diagnosis:	
Comments:	

MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	<input type="checkbox"/> Unable to Locate <input type="checkbox"/> Contact Date: / / <input type="checkbox"/> Advised <input type="checkbox"/> Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:

Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	<input type="checkbox"/> No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: <input type="checkbox"/> Contact Complete: Date: / / <input type="checkbox"/> Unable to Locate: Date: / / <input type="checkbox"/> Referred to: Date: / /
Comments:	