**Case Coordination Unit Referral Form**

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| Date of Referral: | Referred By (Include name, address, email and phone number): |
| Member Name: |
| Member Current Location/Phone: |
| Member DOB: | Guardian Name/Address/Phone: |
| MaineCare Number: |
| Class Member:  Yes  No | Case Manager Name/Location/Phone: |
| Hospital Post-Acute Date (Date Ready for Discharge): |
| Disability Rights Involvement:  Yes  No  DRM Name: | PCP Name/Location/Phone: |
| Member on ED Reduction Project:  Yes  No | Referral to Long Term Care Ombudsman Program (LTCOP):  Yes  No |
| MED Application:  Yes  No  (Referred to as Goold) | LTCOP Referral Date:  LTCOP Contact Name: |
| PNMI Application:  Yes  No  PNMI Application Date: | Member in Jail:  Yes  No  Jail Address: |
| Crisis Involvement:  Yes  No | Probation:  Yes  No |
| Member’s current diagnoses (All): | |
| Member’s current services (Please include provider and contact information): | |
| Services requested of CCU (Please provide **full** details): | |
| What has been done to resolve issue prior to CCU referral (Due diligence required prior to referral): | |
| Barriers to resolving issue: | |
| Other pertinent information to the case: | |