**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 [ ]  NoDRM 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 [ ]  NoPNMI Application Date: | Member in Jail: [ ]  Yes [ ]  NoJail 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:  |