**MOU Care Coordination Request Form**

**Please select which MOU this coordination is being requested for to ensure the appropriate party is available.**

#### [ ]  Child Welfare Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.1 Children’s Emergency Shelter Care Center (Polinsky Children’s Center)

#### [ ]  Behavioral Health Services\_\_\_\_\_\_\_\_\_\_\_\_

2.1 Mental Health Plan (MHP)

2.4 Drug Medi-Cal Organized Delivery System

#### [ ]  Aging and Independent Services \_\_\_\_\_\_\_\_\_\_\_\_

4.1 In Home Supportive Services (IHSS)

4.2 Multipurpose Senior Services Program (MSSP)

#### [ ]  Public Health Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.1 California Children’s Services (CCS)

1.2 Child Health and Disability Prevention (CHDP) Program

1.3 Community Epidemiology

1.4 Immunization Program

1.5 Hansen’s Disease (HD) Program

1.6 Sexually Transmitted Disease (STD) Control Program

1.7 Office of AIDS Coordination (OAC) Program

1.8 Maternal, Child, Adolescent Health (MCAH) Program

1.9 Tuberculosis (TB) Control Program

1.10 Refugee Health Assessment Program (RHAP)

1.11 Targeted Case Management (TCM)

#### [ ]  San Diego Regional Center\_\_\_\_\_\_\_\_\_

* 1. Care Coordination

#### [ ]  Blue Shield Promise\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### [ ]  Community Health Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### [ ]  Kaiser\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### [ ]  Molina Healthcare\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### Required Information

 **DATE:** Click here to enter a date.

**REQUESTING PARTY’S CONTACT INFORMATION**

Name : Click here to enter text. Organization : Click here to enter text. Phone Number : Click here to enter text. E-mail Address : Click here to enter text.

**CLIENT INFORMATION**

Name : Click here to enter text.

DOB : Click here to enter text.

Current Location : Click here to enter text.

CIN #: Click here to enter text.

☐Voluntary ☐Conservatorship

**CLIENT CLINICAL PROFILE**

Diagnosis : Click here to enter text.

Previous Placement: Click here to enter text.

**Reason for Case Conference:**

Click here to enter text.

**Recommended Outcome:**

Click here to enter text.

**Other Community Partners who should be invited, e.g., Case Manager, SD Regional Center, PERT, COR etc.** (*Phone numbers and email addresses are REQUIRED*):

1. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:*Click here to enter text.
2. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:*Click here to enter text.
3. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:*Click here to enter text.
4. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:*Click here to enter text.

*You will be notified of the date, time, and location of the next case conference. Thank you.*