MiCC | MI Community Care
WASHTENAW HEALTH INITIATIVE

A Community-wide Care Coordination Program

Referral Form

Date: _____

MI Community Care, a community-wide care coordination program serving Livingston and Washtenaw County residents, aims to better coordinate physical health, behavioral health, and social services for individuals with complex lives. Participants are assigned to a lead agency that communicates with other local agencies to coordinate needed services. The assigned agency will contact the prospective participant directly to confirm eligibility. Participation is free of charge and does not jeopardize other forms of aid. Enrollment capacity varies; the referring provider will be contacted within three weeks if there is no availability at this time. This program focuses on long-term care management; it is not meant for crisis response.

Referral Information

Name: _____ **Date of Birth:** _____

Phone: _____ **Address:** _____

Preferred language (if other than English): _____ **City** _____ **Zip** _____ **County** _____

Legal sex: ☐ Female ☐ Male

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say ☐ Prefer to self-describe _____

Insurance: ☐ Medicaid ☐ Medicare ☐ Private ☐ Unknown ☐ No insurance / Uninsured

If Medicaid, Medicaid ID# (if known): _____ **Health Insurance Company:** _____

Referral Source

Your Agency: _____ **Referring Person:** _____

Phone: _____ **Relationship to referral:** _____

Who should we coordinate with at your office? _____

Provide name and phone # if different from above.

Agencies: Which other agencies currently provide services to the person being referred?

_____

Please note if the agency is one of those listed on the back of this form. This information helps us assign agency leads.

Referral Criteria:

Must meet three or more of the following criteria. Check the appropriate boxes.

☐ Five or more ED visits in the last 12 months

☐ Homelessness/housing instability

☐ Three or more chronic medical conditions

☐ No primary care engagement in last two years

☐ Mental health or substance use-related needs

☐ Social determinants of health needs
[i.e., food, transportation, utility assistance, insurance needs]

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Goals

Goals you want this program to focus on with the person being referred:
Please include only the minimum necessary information needed for the referral. Do not include sensitive information.

_____

_____

Permissions

Signature of the person being referred: _____ Date: _____

If signature cannot be obtained, confirm that the person consents to the referral by checking this box: ☐

Date: _____

MI Community Care Agencies

Avalon Housing
Corner Health Care
Home of New Vision
Jewish Family Services of Washtenaw County
Livingston County Catholic Charities
Livingston County Community Mental Health
Michigan Medicine
Packard Health
Shelter Association of Washtenaw County
Saint Joseph Mercy Health System
Washtenaw County Community Mental Health
Washtenaw Health Plan

Please send completed MI Community Care referral forms securely to:
Fax: 734-647-0174 (please note, faxes come directly to the email address below)
Email: CHRT-SIMReferrals-Fax@med.umich.edu