Confidential Referral Form

MiCC | MI Community Care
WASHTENAW HEALTH INITIATIVE

Send completed form securely to:

Fax: 734-647-0174 (please note, faxes come directly to the email address below)
Email: CHRT-SIMReferrals-Fax@med.umich.edu

MI Community Care (MiCC)

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

MiCC Affiliated Agencies

Avalon Housing
Corner Health Center
Home of New Vision
Huron Valley Ambulance
Jewish Family Services of Washtenaw County
Livingston County Catholic Charities
Livingston County Community Mental Health
University of Michigan Health
Packard Health
Trinity Health Ann Arbor, Livingston Hospitals
Shelter Association of Washtenaw County
Washtenaw County Community Mental Health
Washtenaw County Health Department
Washtenaw Health Project

Referral Source

Date of referral:

Referring person: **Agency:**

Relationship to person being referred: **Phone:**

Who should we coordinate with at your office *(provide name and phone if different from above)?*

Name: **Phone:**

Service Providers

Which other agencies currently provide services to the person being referred (if known)?

Please note if agency is one of the MiCC agencies listed above (this information helps us assign a lead agency).

Agency 1: **Agency 2:**

Agency 3: **Agency 4:**

Continue form on next page

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Person Being Referred

Name: _____ **Date of birth:** _____

Phone: _____ **Preferred language:** _____

Address: _____

City: _____ **Zip code:** _____ **County:** _____

Sex assigned at birth: ☐ Female ☐ Male

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

Race:

☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Prefer not to answer
☐ Asian
☐ White
☐ Prefer to self-describe: _____
☐ Black or African American

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer ☐ Prefer to self-describe: _____

Insurance:

☐ Medicare ☐ Private ☐ No insurance / Uninsured ☐ Unknown

☐ Medicaid (ID# if known): _____ Insurance company, if known: _____

Referral Criteria

Must meet three or more of these criteria. Check all that apply:

☐ **5 or more ED visits in the last 12 months**
☐ **3 or more chronic medical conditions**
☐ **No primary care engagement in the last 2 years**
☐ **Mental health or substance use related needs**
☐ **Homelessness / housing instability**
☐ **Other social determinants of health or medical needs.** Check all that apply:

☐ Childcare (daycare, pre-school, etc.)
☐ Dental services
☐ Family planning
☐ Health insurance
☐ Medical equipment/supplies
☐ Other (describe): _____
☐ Child support (financial)
☐ Education and school
☐ Financial
☐ Legal services
☐ Transportation
☐ Clothing
☐ Elderly care/support
☐ Food
☐ MDHHS benefits
☐ Utilities

Goals you want MiCC to work on. ***Do not include sensitive information:***

Permissions (this section must be completed for the referral to be processed)

Signature of person being referred (or parent/legal guardian, if applicable): _____

If signature cannot be obtained, confirm the person (or parent/legal guardian, if applicable) consents to the referral by checking this box: ☐

Name of parent/legal guardian (if applicable): _____ Date: _____