LOCAL HEALTH SERVICES REQUEST FORM

PURPOSE: This form is for use by the Managed Care Organization (MCO) to formally members needing outreach and health related services to the Local Health Department Administrative Care Coordination Unit (LDH-ACCU).

An MCO may request assistance from the Local Health Department **only** after it has made documented, unsuccessful attempts to contact and bring care recipients who are difficult to reach or frequently miss scheduled appointments. (COMAR 10.67.05.03).

INSTRUCTIONS FOR USE:

1. **'TO' –** Enter the appropriate LHD based on the member's county of residence.
2. **'FROM' –** Provide information for the referral source, including the contact's name, address, phone number, and fax number.
3. **'MEMBER INFORMATION' –** Include the member's fill name, demographic details, Medicaid Assistance (MA) number, and their last known address and phone number(s).
4. **'FOLLOW-UP' –** Indicate the member's population category [FOR], state the reason for the request, and add and additional information or comments that will help the LHD outreach the member.

MCO Section: When forwarding the form to the LHD-ACCU, please include the following information:

- Indicate the type and total number of outreach attempts made (letters, phone calls, face-to-face).
- Provide the health care provider's full name and phone number.
- Use the "comments" section for any extra details that could help the LHD with member outreach. This may include:
    - The full name and contact information for the head of the household or guardian.
    - Any potential need for interpreter services.
    - Information on the member's diagnosis and/or treatment.
    - Whether the member was recently seen in the Emergency Department.
    - The date of the most recent contact between the MCO and the member or the provider.

Local Health Department Section:

- Clearly state the specific action that was performed.
- Use the "Comments" section to detail any additional case findings that would be helpful to the MCO for continued care coordination of the member.
- Send a copy back to the MCO or provider.

SELECTED DEFINITIONS:

- **MISSED APPOINTMENTS**:
    - Children under 2 years Old: Missing two consecutive EPSDT appointments.
    - Children 2-21 Years Old: Missing two consecutive appointments when treatment is required.
    - Pregnant Individuals: Being 30 days past the scheduled appointment date.
    - Adults with Special Needs: Missing three consecutive appointments for treatment while meeting the established 'special needs' criteria.
- **ADDHERENCE TO PLAN OF CARE:** Non-compliance with treatment plan or medical regime.
- **IMMUNIZATION DELAY**: 60 days past immunization due date.
- **PREVENTABLE HOSPITALIZATION:** Includes inpatient care within the preceding 60 days for dehydration, pneumonia, burns, cellulitis, Failure to Thrive', lead poisoning, ingestion, and/or intentional injuries.
- **OTHER:** Additional information that will assist the LHD with care coordination.

LOCAL HEALTH SERVICES REQUEST FORM

Contact Information

Date: _____
Name: _____
To: _____
Attention: _____
Address: _____ City/State/Zip: _____
Phone Number: _____

Member Information

Name: _____
Phone Number: _____
Address: _____ City/State/Zip: _____
County: _____
Date of Birth: _____ SSN #: _____
Sex: M☐ F☐ Hispanic: Y☐ N☐
Marital Status: Single☐ Married☐ Private Insurance? Y☐ N☐
Interpretation Needed? Y☐ N☐

Race (Check all that apply):

African American/Black☐ Alaskan Native☐
American Native☐ Asian☐
Pacific Islander☐ White☐
Unknown☐

Caregiver/Emergency Contact Name: _____
Relationship: _____
Phone Number: _____

Follow-Up For: (Check all that apply)

Child under 2 years of age☐ Child 2-21 years of age ___
Child with special health care needs☐ Pregnant☐ EDD: _____
Adult with disability (mental, physical, or developmental) ____
Substance use care needed☐ Homeless (at-risk)☐

Related to:

Missed Appointments☐ #Missed: ____
Adherence to plan of care☐ Immunization Delay ☐
Preventable Hospitalization☐ Transportation ☐
Other: _____

Diagnosis:

_____
_____
_____

Comments:

_____
_____
_____

LOCAL HEALTH SERVICES REQUEST FORM

MCO Information

Document Outreach:
# of Letters: ____
# of Face-to-Face outreach efforts: ___
Unable to Locate ☐
Advised ☐
Comments:

Date Received:
# of Phone Call(s): ____
Contact Date: ____
Refused ☐

_____
_____

Contact Person: _____ Phone Number: _____
Fax: _____

Provider Name: _____ Provider Phone Number: _____

Local Health Department (County)

Document Outreach:
# of Letters: ____
# of Face-to-Face outreach efforts: ___
No Action (returned) ____
Reason for return:

Date Received:
# of Phone Call(s): ____

_____
_____

Contact Person: _____ Phone Number: _____
Fax: _____

Disposition:

Contact Complete: ☐ Date: _____
Unable to Locate ☐
Date: _____
Referred to:
Date: _____
Comments:

_____
_____