Synergy Family Services
Enhanced Care Management (ECM) Referral Form

General Information

Agency Information:

- Agency Name: _____
- Referring Staff Name: _____
- Title/Role: _____
- Phone Number: _____
- Email Address: _____

Client Information

- Client Name: _____
- Date of Birth: _____
- Age: _____
- Address: _____
- Phone Number: _____
- Email Address: _____
- Preferred Method of Contact: _____
- Primary Language: _____

Parent/Guardian Information (If Applicable)

- Parent/Guardian Name(s): _____
- Relationship to Client: _____
- Phone Number: _____
- Email Address: _____
- Address (if different from client): _____

Enhanced Care Management (ECM) Support

At Synergy Family Services, Enhanced Care Management (ECM) provides trusted, culturally informed support to individuals and families navigating health, wellness, and social challenges. ECM services help clients access resources, build healthy habits, manage stress, and strengthen life skills. Whether it's connecting to care, setting wellness goals, or learning emotional regulation strategies, our CHWs are here to walk alongside clients every step of the way.

Eligibility Criteria:

- Is the individual covered through Medi-Cal?

❒ Yes ❒ No

ECM Eligibility & Service Information

- Medi-Cal Member ID (if applicable): _____
- Health Plan: _____
- Referral Source: _____
- Reason for ECM Referral: _____
- Current Supports/Services Received: _____
- Primary Needs or Areas of Concern: _____

Service Needs:

Synergy Family Services provides Enhanced Care Management (ECM) support to youth, families, and individuals of all ages. Please indicate the area(s) where the support is needed:

❒ Case management
❒ Housing navigation
❒ Health access & navigation
❒ Emotional & behavioral support
❒ Transportation to appointments
❒ Health education & prevention
❒ Life skills & empowerment
❒ Community resource connection
❒ Other: _____

ReasonforReferral

Reason for Referral to ECM:

❒ Adult with Complex Medical Needs
❒ Adult with Complex Behavioral Needs
❒ Adult with Complex Social Needs
❒ Adult with Complex Medical & Behavioral Health Needs
❒ Children/Youth with Complex Needs
❒ Homeless Families
❒ Other: _____

Please provide a brief explanation of why you are referring the individual for ECM services. Include any relevant background, concerns, or goals for treatment.

Please email the completed form to info@synergy-familyservices.com or mail to P.O. Box 77, Ukiah, CA 95482.


Synergy
Family
Services