



**QUEST Integration CIS Referral Form**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PART 1: REFERRAL SOURCE			
1. Who is referring this member to CIS? <input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Internal Referral <input type="checkbox"/> Another Health Plan <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Medical Provider <input type="checkbox"/> Nursing Home <input type="checkbox"/> Social/Housing Services Provider <input type="checkbox"/> Other Referral Source (specify): _____			
2. Referrer Name:		3. Referring Agency (if applicable):	
4. Referral Date:		5. Contact Phone Number:	
6. Contact Fax Number:		7. Contact E-Mail Address:	
PART 2: MEMBER INFORMATION			
8. Member First Name:	9. Member Last Name:	10. MI:	11. Date of Birth: ____/____/____
12. Member HMIS #:	13. Medicaid ID #:	14. CCS? <input type="checkbox"/> No <input type="checkbox"/> Yes	15. Health Plan: <input type="checkbox"/> HMSA <input type="checkbox"/> Kaiser <input type="checkbox"/> AlohaCare <input type="checkbox"/> Ohana <input type="checkbox"/> United
16. Current Location/Address:		17. City, State, Zip:	
18. Mailing Address (if different from above):		19. City, State, Zip:	
20. Best Contact Phone Number:		21. Best Contact Email Address:	
22. Any friends or family who can help reach member? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name/Phone: _____			
23. Does the member have interpretation needs? <input type="checkbox"/> No <input type="checkbox"/> Yes, Language: _____			
PART 3: PRESUMPTIVE MEMBER ELIGIBILITY INFORMATION (Subject to Verification)			
<i>A member is eligible for CIS if they have <u>both</u> a health need and a homeless risk factor. Please indicate eligibility factors below. ATTACH EVIDENCE OF CHECKED OFF HEALTH NEEDS and RISK FACTORS if known</i>			
PART A: HEALTH NEEDS-BASED CRITERIA		PART B: HOUSING CRITERIA	
<input type="checkbox"/> Mental Health		<input type="checkbox"/> Sheltered or <input type="checkbox"/> Unsheltered Homelessness	
<input type="checkbox"/> Substance Use		<input type="checkbox"/> Risk of Imminent Eviction	
<input type="checkbox"/> Complex Physical Health		<input type="checkbox"/> Frequent Institutional Stays	

**CIS Referral Form Instructions**

Please fax the first page of this form to the appropriate provider with ATTN: QI CIS Program.

<b>AlohaCare</b> Fax: 808-973-0676	<b>HMSA</b> Fax: 808-948-8243	<b>Kaiser</b> Fax: 855-416-0995	<b>Ohana</b> Fax: 855-703-8078	<b>United</b> Fax: 866-314-3005	<b>CCS</b> Fax: 855-703-8078
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If information in boxes 14 and 15 are unavailable or unknown, please fax to Med-QUEST at 808-692-8087.