



Going Home Plus (GHP) Referral Form

Date: ____/____/____

PART 1: REFERRAL SOURCE/AGENCY INFORMATION			
1. Who is referring this member to GHP? <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital <input type="checkbox"/> Self <input type="checkbox"/> Family/Friend <input type="checkbox"/> Medical 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. Medicaid ID #:	13. Health Plan: <input type="checkbox"/> AlohaCare <input type="checkbox"/> HMSA <input type="checkbox"/> Kaiser <input type="checkbox"/> Ohana <input type="checkbox"/> United		
14. Current Location/Address:		15. City, State, Zip:	
16. Island: <input type="checkbox"/> Oahu <input type="checkbox"/> Maui <input type="checkbox"/> East Hawaii <input type="checkbox"/> West Hawaii <input type="checkbox"/> Kauai <input type="checkbox"/> Other _____			
Name of Resident's Authorized Representative, if any (Last, First): _____			
Phone Number of Authorized Representative: _____			
Email Address of Authorized Representative: _____			
PART 3: MEMBER ELIGIBILITY INFORMATION (Subject to Verification)			
<i>All three criteria below have to be met for GHP eligibility</i>			
<input type="checkbox"/> Medicaid and			
<input type="checkbox"/> Approved Level of Care on DHS 1147 or DHS 1150 and			
<input type="checkbox"/> At least 60 <u>continuous</u> days in a hospital, nursing home, ICF-IDD and or rehab facility			

GHP Referral Form Instructions

Please fax the first page of this form to the member's health plan with ATTN: GHP Program.

AlohaCare	HMSA	Kaiser	Ohana	United
Fax: 808-973-7374	Fax: 808-944-5604	Fax: 808-432-3146	Fax: 855-637-2901	Fax: 844-882-6985
For DDD/DOH: Contact DDD/DOH Case Manager				

Updated: February 2, 2024