Mariposa County
Health & Human
Services Agency

Targeted Case Management Referral

Referral forms can be submitted:

In person at 5362 Lemee Lane, via mail at P.O. Box 99, Mariposa, CA 95338, by fax at 209-742-0996 or by email hhsa.medicalrecords@mariposacounty.org

Referral Date: _____

Referring Source Name/Agency: _____

Contact Phone Number: _____ Email: _____

The Targeted Case Management program provides specialized case management services to specific Mariposa County Medi-Cal eligible populations. This program is designed to help link clients with needed resources to include medical, social, educational, and other services when comprehensive case management is not being provided elsewhere. This program is not a crisis intervention program but is intended for the client to actively participate while the TCM case manager provides support, assistance and advocacy for clients in need. After a referral is submitted, the client will be contacted by a TCM case manager to complete additional screening.

TCM Eligibility Criteria:
Please review the following criteria and select all that apply, individuals must meet 1 or more of the target population requirements AND 1 or more of the situation requirements listed in box 2.

Box 1 - Target Population Requirements:
☐ is high risk and under the age of 21
☐ is considered medically fragile
☐ is at risk of institutionalization
☐ is in jeopardy of negative health **or** psycho-social outcomes
☐ has been diagnosed with a communicable disease
Box 2 – Situation Requirements:
☐ Is at risk of compromise OR;
☐ Is in need of assistance in accessing necessary medical, social, education, or other services OR;
☐ Is without comprehensive case management provided by any other publicly funded program

Referred Individual Information

Name:_____ Date of Birth:_____

Gender:_____ Individual identifies as:_____

Address:_____

*If none, is this individual considered homeless or transient: ☐ Yes ☐ No ☐ Other/Unsure

Contact Phone Number:_____ Is it okay to leave a message: ☐ Yes ☐ No

Language Preference:_____ Is an interpreter needed: ☐ Yes ☐ No

If referred individual is under age 18, please provide:

Parent/Legal Guardian Name:_____ Phone Number:_____

Insurance Information:

☐ Medi-cal ☐ Private Insurance ☐ No insurance ☐ Unsure/Other

Medi-cal #: _____

Primary Care Physician: _____

Is client aware of referral: _____

Presenting Problems/Reason for Referral:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

For any additional information or questions, please contact any of the following:

Glori Wessels- (209) 742-0884

Austin Ridenhour- (209) 742-0806

Leslie Ash- (209) 742-0815

Sydney Forga, Program Administrator- (209) 742-0842

OFFICIAL USE ONLY

Date Received by County Staff:_____

Date Forwarded to TCM Staff:_____