



Going Home Plus (GHP) Referral Form

Date: ____/____/____

PART 1: REFERRAL SOURCE/AGENCY INFORMATION

1. Who is referring this member to GHP?

- ☐ Nursing Home ☐ Hospital ☐ Self ☐ Family/Friend ☐ Medical Provider
☐ 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:

- ☐ AlohaCare ☐ HMSA ☐ Kaiser ☐ Ohana ☐ United

14. Current Location/Address: _____

15. City, State, Zip: _____

16. Island: ☐ Oahu ☐ Maui ☐ East Hawaii ☐ West Hawaii ☐ Kauai
☐ 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)

All three criteria below have to be met for GHP eligibility

☐ Medicaid and

☐ Approved Level of Care on DHS 1147 or DHS 1150 and

☐ At least 60 continuous 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:	Fax:	Fax:	Fax:	Fax:
808-973-7374	808-944-5604	808-432-3146	855-637-2901	844-882-6985
For DDD/DOH: Contact DDD/DOH Case Manager				