STATE OF HAWAII
Department of Human Services
Med-QUEST Division

QUEST Integration CIS Referral Form

Date: ____/____/_____

PART 1: REFERRAL SOURCE	
1. Who is referring this member to CIS? ☐ Self ☐ Family/Friend ☐ Internal Referral ☐ Another Health Plan ☐ Correctional Facility ☐ Medical Provider ☐ Nursing Home ☐ Social/Housing Services 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. Member HMIS #:	13. Medicaid ID #:	14. CCS? ☐ No ☐ Yes	15. Health Plan: ☐ HMSA ☐ Kaiser ☐ AlohaCare ☐ Ohana ☐ 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? ☐ No ☐ Yes, Name/Phone:			
23. Does the member have interpretation needs? ☐ No ☐ Yes, Language:			

PART 3: PRESUMPTIVE MEMBER ELIGIBILITY INFORMATION (Subject to Verification)

A member is eligible for CIS if they have both 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

PART A: HEALTH NEEDS-BASED CRITERIA	PART B: HOUSING CRITERIA
☐ Mental Health	☐ Sheltered or ☐ Unsheltered Homelessness
☐ Substance Use	☐ Risk of Imminent Eviction
☐ Complex Physical Health	☐ Frequent Institutional Stays

CIS Referral Form Instructions

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

AlohaCare Fax:	**HMSA** Fax:	**Kaiser** Fax:	**Ohana** Fax:	**United** Fax:	**CCS** Fax:
808-973-0676	808-948-8243	855-416-0995	855-703-8078	866-314-3005	855-703-8078

If information in boxes 14 and 15 are unavailable or unknown, please fax to Med-QUEST at 808-692-8087.