

**CMISP PATIENT REFERRAL FORM****SECTION 1: INSTRUCTIONS****A. COVERAGE**

- Sacramento **County Medically Indigent Services Program (CMISP)** may be able to pay for the medical services listed below if the patient is not eligible for any other health care coverage programs and is a legal Sacramento County resident.
- *The patient must go to the County Clinic (located at 4600 Broadway), for any needed follow up care, unless it is an emergency. Always call 911 or go to the ER for a medical emergency.*
- This Referral and Medi-Cal application must be e-faxed to the County within 30 days of treatment or discharge at (916) 854-9272. County staff will reach out to the patient if further information or verification is needed. The patient **MUST** turn in any proof that the County requests.
- This application will be used to evaluate the patient for Medi-Cal, Covered CA, and CMISP respectively. Via the Medi-Cal eligibility process, Covered CA eligibility will be assessed by the State of California.
- Patients that are not Sacramento County residents will need to apply for county health coverage **in their county of residence**.

**B. GOOD CAUSE**

- If the patient applies more than 30 days after the hospital care, without good reason, it may cause a delay in payment or a denial of eligibility. If turning in this form more than 30 days after treatment, list the reason you are late (for example, extended illness, death in family, transportation not available, etc...)

**SECTION 2: To be completed by Hospital or County Clinic****Medical Facility:** ☐ County Clinic☐ Kaiser North ☐ Kaiser Roseville ☐ Kaiser South ☐ Methodist Hospital South☐ Mercy General ☐ Mercy Hospital of Folsom ☐ Mercy San Juan ☐ Sutter Roseville☐ Sutter Sacramento ☐ UC Davis Medical Center☐ Other \_\_\_\_\_**Medical Facility Phone #:** \_\_\_\_\_**Patient Name:** \_\_\_\_\_Gender: ☐ Male ☐ Female ☐ Other

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address (if different than home): \_\_\_\_\_

**Service Related Information:**

Medical Record Number (MRN): \_\_\_\_\_

☐ Inpatient Admission Admit Date: \_\_\_\_\_ Time: \_\_\_\_\_

Discharge Date: \_\_\_\_\_ Time: \_\_\_\_\_

☐ Treated/Discharged from ER Begin Date: \_\_\_\_\_

End Date: \_\_\_\_\_

☐ Treated at County Clinic Date: \_\_\_\_\_

Describe Illness/Injury: \_\_\_\_\_

Treatment Related To: ☐ Crime ☐ Vehicle Accident ☐ Work/Job ☐ Other (specify): \_\_\_\_\_Follow-Up Care: ☐ None ☐ Follow-Up Care Needed ☐ Prescription Needed**I certify that treatment was provided at the medical facility, as listed above.****Hospital or Clinic Representative Full Name****Hospital or Clinic Representative Signature****Date**

County Specific Referral

CMISP 1015\_34F (10/2026) Patient Referral

**SECTION 3: To be completed by PATIENT****MEDICAL RECORDS**

The County will need your medical records to see that this was an emergency or other qualifying medically necessary care.

Sign below so we can get these records for you.

By signing below, I give permission to the hospital listed above to send Sacramento County, Department of Health Services any records or information about the listed visit. I know that I am not required to sign this release, and can get the records myself. This authorization will end in 1 year, or an earlier date that I must tell the County. This information will only be used to see if I am eligible for Sacramento County, Department of Health Services for the services listed on this form.

I know that I must give specific consent to release certain kinds of information. I give this consent by marking the box(es) below AND putting my initials next to what I want released. I specifically consent to the release of information about:

- ☐ Drug and/or alcohol abuse diagnosis or treatment. Initials: \_\_\_\_\_
- ☐ Mental health diagnosis or treatment (excluding psychotherapy notes). Initials: \_\_\_\_\_
- ☐ HIV/AIDS testing, diagnosis, or treatment. Initials: \_\_\_\_\_
- ☐ Genetic testing. Initials: \_\_\_\_\_
- ☐ All records. Initials: \_\_\_\_\_

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**Patient Full Name****Patient Signature****Date**