



## Community Supports Member Referral Form

California | Anthem Blue Cross | Medi-Cal Managed Care (Medi-Cal)

Community Supports (CS) refers to services that are flexible, wrap-around supports designed to fill medical and socially determined health gaps. The services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. To be eligible for CS, members must meet specific eligibility requirements. Contracted community-based CS providers will provide services to approved members.

**Note:** Complete this page and any additional requested services on the following pages.

Submit the referral form by:

- Secure email: [CalAIMReferrals@anthem.com](mailto:CalAIMReferrals@anthem.com)
- By fax at **877-734-1857**

Call one of our Medi-Cal Managed Care (Medi-Cal) Customer Care Centers at:

- **800-407-4627** (outside L.A. County)
- **888-285-7801** (inside L.A. County)

Referral source information	
External referral by (select one):	<input type="checkbox"/> Hospital
	<input type="checkbox"/> Primary medical group (PMG)
	<input type="checkbox"/> PCP
	<input type="checkbox"/> Clinic
	<input type="checkbox"/> Enhanced care management (ECM) provider
	<input type="checkbox"/> Other
Referring individual name:	
Referring individual relationship to member:	
Referring organization name:	
Referring organization NPI:	
Referrer phone number:	
Referrer fax number:	
Referrer email address:	
Member provides consent for requested services	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Referral source information**

By marking this box, you are attesting that all information provided on this form has been validated. Also, where indicated on this form that you have captured member consent, you will be able to present documentation substantiating this claim with dates, times, signature, voice capture, and/or phone records which will be required upon any prospective audit.

**Note to referrers:** Please only mark the services you are referring to.

**Member information**

Member name:	
Member Medi-Cal client ID # (CIN):	
Member DOB:	
Member address:	
Member primary phone number:	
Best time to contact:	
Member preferred name:	
Caregiver name:	
Caregiver's phone number (if available):	
Care manager name:	
Care manager contact information:	
Care manager contact information:	

**☐ Medically tailored meals/medically supportive food**

This service provides up to two meals per day and/or medically supportive food (for example, a weekly voucher) and nutrition services for up to 12 weeks or longer if medically necessary. Meals/food are not provided to respond solely to food insecurity.

**Exclusions:** If the member is receiving other meal delivery services or weekly vouchers from local, state, or federally funded programs, then the member is not eligible. However, federal nutrition programs such as CalFresh, WIC, Meals on Wheels, and child nutrition programs are not considered duplicative with Community Supports.

**Please mark if the member has any of the following chronic conditions:**

<input type="checkbox"/> Diabetes
<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Chronic lung disorders
<input type="checkbox"/> Human immunodeficiency virus (HIV)
<input type="checkbox"/> Cancer
<input type="checkbox"/> Gestational diabetes, or other high risk perinatal conditions
<input type="checkbox"/> Chronic or disabling mental/behavioral health disorders
<input type="checkbox"/> Other

**If the member is ECM enrolled, provide ECM provider name/contact:**

<input type="checkbox"/> <b>Medically tailored meals/medically supportive food</b>	
<input type="checkbox"/> Prefers meal deliveries	
<input type="checkbox"/> Prefers supportive food	
<input type="checkbox"/> Prefers voucher	
If CS services have begun, indicate the service start date:	
<b>Documentation</b>	
We recommend you upload one or more of the following documents with this request:	
<ul style="list-style-type: none"> <li>• Documentation/office visit notes with diagnosis or identification of chronic illness requiring special diet</li> </ul>	
<ul style="list-style-type: none"> <li>• Skilled nursing discharge plan</li> </ul>	
<ul style="list-style-type: none"> <li>• Documentation from support agencies indicating services/supports member needs or receives</li> </ul>	
<ul style="list-style-type: none"> <li>• Emergency department, inpatient, skilled nursing discharge paperwork</li> </ul>	
<ul style="list-style-type: none"> <li>• Medication/treatment orders</li> </ul>	

  

<input type="checkbox"/> <b>Housing transition navigation services:</b>
<p>I acknowledge that this request does not include room and board. This service includes tenant screening and housing assessment, housing support plan, searching for housing, assistance with securing housing (applications/documentation), benefit advocacy, identifying/securing resources for rent subsidy and expenses, assisting with reasonable accommodations, landlord education/engagement, ensuring living environment safety/move-in readiness, advocacy with landlords, move-in support, housing support crisis plan, transportation resources, and environmental modifications as necessary.</p>
<p><input type="checkbox"/> By marking this box, you are attesting that all information provided in this section is true and accurate.</p>
<b>The member must meet at least one of the following criteria and sub criterion when indicated:</b>
The member is prioritized for a unit through Coordinated Entry System (CES): <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> The member is prioritized for a permanent supportive housing unit or rental subsidy through the Coordinated Entry System (CES) or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.
<b>The member meets the HUD definition of homeless:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The member must meet one or more in both sections to be eligible:</b>
<input type="checkbox"/> Primary nighttime residence is not meant for human habitation
<input type="checkbox"/> Lives in a temporary shelter (hotel, motel, congregate shelter, transitional housing, paid for by a local, state, or federal program)

<b><input type="checkbox"/> Housing transition navigation services:</b>
<input type="checkbox"/> Is exiting an institution where member resided for 90 days or less and resided in an emergency shelter or place not meant for human habitation immediately before entering
<input type="checkbox"/> An individual or family who received written notice to vacate their residency within 14 days since the date they applied for CS, and has not identified subsequent housing, and does not have the resources or support need to obtain other permanent housing
<input type="checkbox"/> An individual or family who is fleeing, or attempting to flee domestic violence, has no other residence, and lacks the resources or networks needed to obtain other permanent housing <b>and</b> meets at least one:
<input type="checkbox"/> Enrolled in ECM
<input type="checkbox"/> Has one or more chronic conditions
<input type="checkbox"/> Has a serious mental illness
<input type="checkbox"/> Risk of institutionalization or requiring residential services due to SUD
<b>Member is at risk of homelessness: <input type="checkbox"/> Yes <input type="checkbox"/> No</b>
<input type="checkbox"/> Member meets HUD's definition of at risk of homelessness, has an income below 30% of the area median family income, and does not have sufficient resources or support networks (such as family, friends, faith based, or other social networks) to prevent them from moving into an emergency shelter or another place described as homeless <b>and</b> meets at least one:
<input type="checkbox"/> Has moved two or more times in the last 60 days due to economic reasons
<input type="checkbox"/> Is living in someone else's home due to economic hardship
<input type="checkbox"/> Received written notice to vacate their home within 21 days since the day they applied for CS
<input type="checkbox"/> Lives in a hotel or motel and cost is not paid for by a local, state, or federal organization
<input type="checkbox"/> Lives in an SRO or efficiency unit where two or more persons reside, or living in a large housing unit where there are more than 1.5 people per room residing
<input type="checkbox"/> Is exiting a publicly funded institution or system of care
<input type="checkbox"/> Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, <b>as identified in the recipient's approved Con Plan.</b>
<b>Members at risk of homelessness must also meet at least one of the following:</b>
<input type="checkbox"/> One or more serious chronic conditions
<input type="checkbox"/> One or more serious mental illness
<input type="checkbox"/> At risk of institutionalization, overdose, or requiring services due to SUD, or has a serious emotional disturbance (children and adolescents)
<input type="checkbox"/> Enrolled in ECM
<input type="checkbox"/> Transition-age youth with significant barriers to housing instability (such as conviction(s), history of foster care, involvement with the juvenile justice or criminal justice system, serious

<b><input type="checkbox"/> Housing transition navigation services:</b>	
mental illness, serious emotional disturbance, survivor of human trafficking or domestic violence)	
<b>Child or youth experiencing homelessness: The member is child or youth that does not qualify as homeless under this section but qualifies as homeless <input type="checkbox"/> Yes <input type="checkbox"/> No under:</b>	
<input type="checkbox"/> <i>Runaway and Homeless Youth Act</i> 42 U.S.C. 2732a – Section 387 Under 18 and it is not safe to live at home and has no other safe alternative living arrangement	
<input type="checkbox"/> <i>Head Start Act</i> 42 U.S.C. 9832 – Section 637 Sharing housing with others due to economic hardship, emergency shelters, or living in places not meant for human habitation, or other unsafe housing conditions (including migrant children and youth)	
<input type="checkbox"/> <i>Violence Against Women Act</i> 42 U.S.C. 14043E-2 Sharing housing with others due to economic hardship, living in an emergency shelter or similar, or living in a place not meant for human habitation	
<input type="checkbox"/> <i>Public Health Service Act</i> 42 U.S.C. 254(h) – Section 330 (h) Lacks housing, includes if primary nighttime residence is a supervised public or private facility that provides temporary accommodations, or in transitional housing	
<input type="checkbox"/> <i>Food and Nutrition Act of 2008</i> 7 U.S.C. 2012 – Section 3 Lacks a fixed and regular nighttime residence or is part of a nighttime residence that is a publicly or privately operated shelter, an institution that provides temporary residence for individuals intended to be institutionalized or in a temporary accommodation (not more than 90 days) or lives in a place not meant for regular sleeping for human beings.	
<b>Child or youth experiencing homelessness and their parent(s) or guardian(s): member is a child or youth, and their parent(s) or guardian(s), who does not qualify as homeless under this section but qualifies as homeless under:</b>	
<input type="checkbox"/> <i>McKinney-Vento Homeless Assistance Act</i> 42 U.S.C. 11434a – Section 725 Meets the definition of homeless under HUD or other Federal statutes. Has experienced a long-term period without living independently in permanent housing, or experienced persistent instability, or can be expected to continue in such a status for an extended period of time due to chronic disabilities, physical or mental health conditions, dependency, history of domestic violence or child abuse, the presence of a child/youth with a disability, or multiple barriers to employment	
<b>Additional comments:</b>	
<b>If CS services have begun, indicate the service start date:</b>	
<b>Documentation</b>	
<b>We recommend you upload one or more of the following documents with this request:</b>	
<ul style="list-style-type: none"> <li>Documentation of homelessness or at risk for homelessness by service providers, PCPs, specialists, or outreach providers</li> </ul>	

**☐ Housing transition navigation services:**

- Documentation of entries/exits from shelters
- Notices from current landlord
- Financial statements

**☐ Housing tenancy and sustaining services:**

Services are for maintaining a safe and stable tenancy once housing is secured. Services can include the identification and intervention of behaviors that jeopardize housing, education on role/rights/responsibilities of the tenant and landlord, coaching on maintaining and developing landlord/property managers, assistance with landlord/neighbor disputes, advocacy/linkage to community resources, benefits advocacy, and assistance with annual housing recertification (review/update/modify).

**The member must meet at least one of the following criteria and sub criterion when indicated:**

☐ By marking this box, you are attesting that all information provided in this section is true and accurate.

**The member is prioritized for a unit through Coordinated Entry System (CES): ☐ Yes ☐ No**

☐ The member is prioritized for a permanent supportive housing unit or rental subsidy through the Coordinated Entry System (CES) or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

**The member meets the HUD definition of homeless: ☐ Yes ☐ No**

**The member must meet one or more in both sections to be eligible:**

☐ Primary nighttime residence is not meant for human habitation

☐ Lives in a temporary shelter (hotel, motel, congregate shelter, transitional housing, paid for by a local, state, or federal program)

☐ Is exiting an institution where member resided for 90 days or less and resided in an emergency shelter or place not meant for human habitation immediately before entering

☐ An individual or family who received written notice to vacate their residency within 14 days since the date they applied for CS, and has not identified subsequent housing, and does not have the resources or support need to obtain other permanent housing

☐ An individual or family who is fleeing, or attempting to flee domestic violence, has no other residence, and lacks the resources or networks needed to obtain other permanent housing **and** meets at least one:

☐ Enrolled in ECM

☐ Has one or more chronic conditions

☐ Has a serious mental illness

☐ Is at risk of institutionalization or requiring residential services due to SUD

**The member is at risk of homelessness ☐ Yes ☐ No**

☐ **Housing tenancy and sustaining services:**

☐ The member meets HUD's definition of at risk of homelessness, has an income below 30% of the area median family income, and does not have sufficient resources or support networks (such as family, friends, faith based, or other social networks) to prevent them from moving into an emergency shelter or another place described as homeless **and** meets at least one:

☐ Has moved more than two times in the last 60 days due to economic reasons

☐ Is living in someone else's home due to economic hardship

☐ Received written notice to vacate their home within 21 days since the day they applied for CS

☐ Lives in a hotel or motel and cost is not paid for by a local, state, or federal organization

☐ Lives in an SRO or efficiency unit where two or more persons reside, or living in a large housing unit where there more than 1.5 people per room residing

☐ Is exiting a publicly funded institution or system of care

☐ Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, **as identified in the recipient's approved Con Plan.**

**Members at risk of homelessness must also meet at least one of the following:**

☐ One or more serious chronic conditions

☐ One or more serious mental illness

☐ At risk of institutionalization, overdose, or requiring services due to SUD, or has a serious emotional disturbance (children and adolescents)

☐ Enrolled in ECM

☐ Transition-age youth with significant barriers to housing instability (such as conviction(s), history of foster care, involvement with the juvenile justice or criminal justice system, serious mental illness, serious emotional disturbance, or survivor of human trafficking or domestic violence)

**Child or youth experiencing homelessness: The member is child or youth that does not qualify as homeless under this section but qualifies as homeless under: ☐ Yes ☐ No**

☐ *Runaway and Homeless Youth Act* 42 U.S.C. 2732a – Section 387 Under 18 and it is not safe to live at home and has no other safe alternative living arrangement

☐ *Head Start Act* 42 U.S.C. 9832 – Section 637 Sharing housing with others due to economic hardship, emergency shelters, or living in places not meant for human habitation, or other unsafe housing conditions (including migrant children and youth)

☐ *Violence Against Women Act* 42 U.S.C. 14043E-2 – Sharing housing with others due to economic hardship, living in an emergency shelter or similar, or living in a place not meant for human habitation

<b><input type="checkbox"/> Housing tenancy and sustaining services:</b>	
<input type="checkbox"/> <i>Public Health Service Act 42 U.S.C. 254(h)</i> – Section 330 (h) lacks housing, includes if primary nighttime residence is a supervised public or private facility that provides temporary accommodations, or in transitional housing	
<input type="checkbox"/> <i>Food and Nutrition Act of 2008 7 U.S.C. 2012</i> – Section 3 Lacks a fixed and regular nighttime residence or is part of a nighttime residence that is a publicly or privately operated shelter, an institution that provides temporary residence for individuals intended to be institutionalized or in a temporary accommodation (not more than 90 days) or lives in a place not meant for regular sleeping for human beings.	
<input type="checkbox"/> <i>Child Nutrition Act of 1966 42 U.S.C. 1786(b)</i> – Section 17 (b) lacks a fixed regular nighttime residence or is part of a temporary publicly or privately operated shelter, or living in an institution that provides a temporary residence for individuals intended to be institutionalized, or have a temporary accommodation of not more than 365 days in the residence of another individual, or a public or private place not meant for regular sleeping for human beings	
<b>Child or youth experiencing homelessness and their parent(s) or guardian(s): member is a child or youth, and their parent(s) or guardian(s), who does not qualify as homeless under this section but qualifies as homeless under: <input type="checkbox"/> Yes <input type="checkbox"/> No</b>	
<input type="checkbox"/> <i>McKinney-Vento Homeless Assistance Act 42 U.S.C. 11434a</i> – Section 725 Meets the definition of homeless under HUD or other Federal statutes. Has experienced a long-term period without living independently in permanent housing, or experienced persistent instability, or can be expected to continue in such a status for an extended period of time due to chronic disabilities, physical or mental health conditions, dependency, history of domestic violence or child abuse, the presence of a child/youth with a disability, or multiple barriers to employment	
<b>Member at risk of experiencing homelessness: <input type="checkbox"/> Yes <input type="checkbox"/> No and meets at least one:</b>	
<input type="checkbox"/> One or more serious chronic conditions	
<input type="checkbox"/> One or more serious mental illness	
<input type="checkbox"/> At risk of institutionalization, overdose, or requiring services due to SUD, or has a serious emotional disturbance (children and adolescents)	
<input type="checkbox"/> Enrolled in ECM	
<input type="checkbox"/> Transition-age youth with significant barriers to housing instability (such as conviction(s), history of foster care, involvement with the juvenile justice or criminal justice system, serious mental illness, serious emotional disturbance, or survivor of human trafficking or domestic violence)	
<b>Additional comments:</b>	
<b>If CS services have begun, indicate the service start date:</b>	



☐ **Housing tenancy and sustaining services:**

**Documentation**

We require you upload one or more of the following documents with this request:

- Housing support plan

☐ **Housing deposit services**

Identification, coordinating, securing, or funding one-time services and modifications necessary to enable the member to establish a basic household. Funding to support security deposits, set-up fees/deposits for utilities, first month's rent and deposit (not to exceed one month's rent), services necessary for member's health and safety, goods/medically necessary adaptive aides to preserve the member's health and safety in the home, and basic household items to establish a household upon move-in.

Does not include provisions beyond first month's rent. **Does not include rental assistance or rent in arrears.** Housing deposits are available once in a member's lifetime. Lifetime maximum of \$7,500.

If a member does not have an individualized housing support plan, refer to Housing Transition and Navigation first.

**Members must meet all of the following to be considered for housing deposits:**

☐ The member attests to not have used this once in a lifetime benefit

☐ Referring party attests that member has been informed of additional information and resources around housing vouchers.

☐ The member has an Individualized Housing Support Plan which is included with the referral

**Documentation**

**Non-contracted providers must include one or more of the following documents with this request. For contracted providers, any of the following may be requested:**

- Lease agreements or signed documentation from lessor indicating required move in cost including line-item cost and total amount. Must match what the actual lease agreement states once available
- Utility bill/deposit agreement
- Updated housing support plan showing members current goals
- *W-9 Form* of the payee including current contact information and address in which payment will be sent. If requesting payment by automatic clearing housing/direct deposit bank information and voided check will be required.
- Financial statements, or attestation member will be able to support the ongoing rent amounts

**For basic household items, please also attach the household item list spreadsheet (to be completed with the member).**

☐ **Nursing facility transition/diversion services to an assisted living facility, residential care facility, or adult residential facility**

**Option one:** This service is for members residing in the community, who are at risk of imminent need for nursing facility level of care and are willing to reside in an assisted living facility as an alternative to long-term placement in a nursing facility.

or

**Option two:** This service is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF).

Is the member interested in remaining in the community, home like setting as an alternate to a nursing facility? ☐ Yes ☐ No

Are they willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services? ☐ Yes ☐ No ☐ Unknown

Do they meet minimum criteria for nursing facility level of care (unable to complete ADLs without assistance)?

☐ Yes ☐ No

Have they in a nursing facility for 60 or more days? ☐ Yes ☐ No ☐ Unknown

Are they able to pay for their own living expenses? ☐ Yes ☐ No

If CS services have begun, please indicate the service start date:

**Documentation**

**We recommend you upload one or more of the following documents with this request:**

- Documentation from support agencies indicating services/supports member needs or receives
- Documentation/office visit notes with diagnosis and identification of frailty
- Documentation from support agencies indicating services/supports member needs or receives
- Medication/treatment orders

☐ **Community transition services/nursing facility transition to a home**

Non-recurring set-up expenses for members who are transitioning from a licensed facility to a living arrangement in a private residence where the member is directly responsible for their own living expenses.

Is the member currently residing in a nursing facility and in lieu of remaining in the nursing facility is choosing to transition home? ☐ Yes ☐ No

Have they in a nursing facility for 60 or more days? ☐ Yes ☐ No ☐ Unknown

Are they willing and able to reside safely in a home with cost effective supports and service? ☐ Yes ☐ No

If CS services have begun, please indicate the service start date:

**☐ Community transition services/nursing facility transition to a home****Documentation****We recommend you upload one or more of the following documents with this request:**

- Skilled nursing discharge plan/paperwork
- Documentation from support agencies indicating services/supports member needs or receives
- Documentation/office visit notes with diagnosis and identification of frailty
- Documentation of home modifications/services completed
- Medication/treatment orders

**☐ Environmental accessibility adaptations (EAA), also known as home modifications**

Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a member, or enable the member to function with greater independence in the home, without which the member would require institutionalization. Lifetime cap is \$7,500.

Is the member at risk of institutionalization in a nursing facility or living in the community and at risk of hospitalization without home modifications? ☐ Yes ☐ No

Is the home owned, leased, rented, or occupied by the member? ☐ Yes ☐ No

This request is for:

- ☐ Equipment
- ☐ Home modification
- ☐ Personal emergency response (PERS)

**Documentation****We require you upload one or more of the following documents with this request:**

- The member's current licensed healthcare provider's order specifying the requested modifications and/or equipment
- Depending on the type of modifications or equipment requested, documentation from the provider describing how the modifications meets the medical needs of the member is required. A brief, written evaluation specific to the member describing how and why the modifications meet the needs of the member will still be necessary.
- A home visit can be or has been conducted to determine the suitability of any requested modifications.

**☐ Asthma remediation services, also known as asthma trigger remediations**

Physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the member or enable the member to function in the home while reducing acute asthma episodes that could result in the need for emergency services and hospitalization. Lifetime cap is \$7,500.

**The member has poorly controlled asthma documented by:**

- ☐ Emergency department visit.
- ☐ Hospitalization.
- ☐ Two sick/urgent care visits in past 12 months.
- ☐ Score of  $\leq 19$  on asthma control test.

<input type="checkbox"/> <b>Asthma remediation services, also known as asthma trigger remediations</b>
Is the home owned, leased, rented, or occupied by the member? <input type="checkbox"/> Yes <input type="checkbox"/> No
This request is for (mark all that apply):
<input type="checkbox"/> Equipment
<input type="checkbox"/> Home modification
Has an asthma remediation home assessment been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Documentation</b>
Please upload the following documents with this request:
<ul style="list-style-type: none"> <li>The member's current licensed healthcare provider's order specifying the requested remediation(s)</li> <li>In- home environmental trigger assessment conducted within the last 12 months to determine the suitability of any requested remediation(s)</li> </ul>

<input type="checkbox"/> <b>Day habilitation</b>
Provided in-home or out-of-home, non-facility setting. Programs designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills to remain in their natural environment.
<b>What is the member's housing status? (choose one)</b>
<input type="checkbox"/> Homeless
<input type="checkbox"/> Chronically homeless
<input type="checkbox"/> At risk of homelessness or institutionalization and whose housing stability could be improved through participation in a day habilitation program
<input type="checkbox"/> Entered housing in the last 24 months
<b>The member is participating in :</b>
<input type="checkbox"/> Housing navigation
<input type="checkbox"/> Housing tenancy and sustaining services
<b>The member would benefit from the following training:</b>
<input type="checkbox"/> Use of public transportation
<input type="checkbox"/> Personal skills development in conflict resolution
<input type="checkbox"/> Community participation
<input type="checkbox"/> Developing and maintaining interpersonal relationships
<input type="checkbox"/> Daily living skills (cooking, cleaning, shopping, money management)
<input type="checkbox"/> Community resources awareness such as police, fire, or local services to support independence
<input type="checkbox"/> Selecting and moving into a home
<input type="checkbox"/> Locating and choosing suitable housemates
<input type="checkbox"/> Locating household furnishings
<input type="checkbox"/> Managing personal financial affairs

<input type="checkbox"/> <b>Day habilitation</b>	
<input type="checkbox"/> Dealing with and responding appropriately to governmental agencies and personnel	
<input type="checkbox"/> Asserting civil and statutory rights through self-advocacy	
<input type="checkbox"/> Building and maintaining interpersonal	
<input type="checkbox"/> Other	
If CS services have begun, indicate the service start date:	
<b>Documentation</b>	
We recommend you upload one or more of the following documents with this request:	
<ul style="list-style-type: none"> <li>• Documentation of housing status by service providers, PCP, specialists, or outreach providers</li> </ul>	
<ul style="list-style-type: none"> <li>• Documentation of participation in housing navigation or housing tenancy and sustaining services</li> </ul>	
<ul style="list-style-type: none"> <li>• Plan of care showing members support needs, services to be provided and frequency of supports being requested</li> </ul>	

<input type="checkbox"/> <b>Personal care and homemaker services</b>	
This service includes assistance with activities of daily living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. In addition, it can include assistance with instrumental activities of daily living (IADLs) such as meal preparation, grocery shopping, and money management. Homemaker or chore services include help with tasks such as cleaning, shopping, and laundry. This service aids members who would not otherwise be able to remain in their homes. Services available through IHSS should always be utilized first. Please make sure to answer all questions in this section.	
Requesting urgent/expedited review? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>The member must meet one of the two:</b>	
<input type="checkbox"/> At risk for hospitalization or institutionalization in a nursing facility.	
<input type="checkbox"/> Member needs assistance with their activities of daily living (ADL) <b>and</b> meets one of the four following criteria:	
1. The member has applied for in-home supportive services (IHSS) and is pending approval <input type="checkbox"/> Yes <input type="checkbox"/> No	
a. If yes, provide the IHSS referral date	
b. If no, ensure the member applies prior to referring to Community Supports at <a href="http://cdss.ca.gov/in-home-supportive-services">cdss.ca.gov/in-home-supportive-services</a> .	
2. The member is currently receiving IHSS, needs additional IHSS hours, the reassessment request is pending, and the caregiver is needed for support in the meantime. <input type="checkbox"/> Yes <input type="checkbox"/> No	
a. If yes, provide reassessment request date	
b. IHSS Hours per month	
3. The member has been approved for the maximum amount of IHSS hours (283 hours/month) but needs additional support. <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. The member is not eligible for IHSS and needs services to help avoid a short term stay in a skilled nursing facility (not to exceed 60 days). <input type="checkbox"/> Yes <input type="checkbox"/> No	
a. If yes, provide the IHSS Notice of Action indicating denial if available.	
<b>Documentation</b>	

<b>We require you upload one or more of the following documents with this request:</b>	
<ul style="list-style-type: none"> <li>• Documentation/office visit notes with diagnosis and identification of frailty</li> <li>• Assessments identifying members physical needs</li> <li>• Documentation from support agencies indicating services/supports member needs or receives (this includes IHSS documents and IHSS Case ID number)</li> <li>• Physical therapy/durable medical equipment evaluation documenting safety needs</li> <li>• Medication/treatment orders</li> </ul>	
<b>Personal Care &amp; Homemaker and Respite services Questionnaire</b> — Please have the ECM provider, member, or caregiver complete the following questionnaire to expedite the request.	
<b>On a scale of one to five, how much help does the member need with the following activities:</b>	
<b>Housework</b>	<b>Food shopping</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help
<b>Other shopping and errands</b>	<b>Meal preparation</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help
<b>Meal clean up</b>	<b>Bed/baths/bathing</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help

<b>Mobility inside/ambulation</b>	<b>Dressing</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help
<b>Grooming</b>	<b>Bowel/bladder</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help
<b>Repositioning</b>	<b>Transfer</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help
<b>Eating/feeding</b>	<b>Laundry</b>
<input type="checkbox"/> 1 = no help needed	<input type="checkbox"/> 1 = no help needed
<input type="checkbox"/> 2 = very little help needed, a reminder to complete	<input type="checkbox"/> 2 = very little help needed, a reminder to complete
<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time	<input type="checkbox"/> 3 = need someone to stand by and physically assist me some of the time
<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time	<input type="checkbox"/> 4 = need someone to assist me with task and physically most of the time
<input type="checkbox"/> 5 = dependent, unable to complete without help	<input type="checkbox"/> 5 = dependent, unable to complete without help

Include clinical or other relevant information to help determine the member's need for personal care and homemaker services.	
<b>Who is completing the questionnaire?</b>	
Name:	
Relationship to the member:	
Contact:	
<input type="checkbox"/> <b>Recuperative care or medical respite care</b>	
<p>Short-term residential care for members who no longer require hospitalization but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, this service includes interim housing with bed and meals and ongoing monitoring of the members medical or behavioral health condition. Service is limited to a continuous 90-day stay:</p> <ul style="list-style-type: none"> <li>• If the member is homeless, consider requesting Housing Transition and Enhanced Case Management services at this time.</li> <li>• No preapproval is required. To avoid discharge delays if the member is currently inpatient and eligible, the discharge planner can coordinate safe discharge directly to a contracted recuperative care facility. Visit <b>Find Care</b> and search by zip code to find the nearest contracted recuperative care facility.</li> </ul>	
<b>The member:</b>	
<input type="checkbox"/> Is at risk of hospitalization	
<input type="checkbox"/> Is post-hospitalization and needs to heal from injury or illness	
<input type="checkbox"/> Lives alone with no formal support	
<input type="checkbox"/> Faces housing insecurity or has housing that would jeopardize his or her health and safety without modification	
<b>If the member has already been admitted to a recuperative care facility, include the following information:</b>	
Facility name:	
Facility NPI:	
Date of admission:	
<b>Documentation</b>	
<b>We require you upload one or more of the following documents with this request:</b>	
• Emergency department, inpatient, or skilled nursing discharge paperwork	
• Documentation of homelessness by service providers, PCPs, specialists, or outreach providers	
• Documentation of entries/exits from shelters	
• Documentation from any support agency indicating services/supports member needs	
• Documentation/office visit notes with diagnosis and identification of frailty	
• Assessment determining limitations in ADLs	
• Medication/treatment orders	



**☐ Short-term post hospitalization housing**

This service provides housing for members who do not have a residence and who have complex medical or behavioral health needs with the opportunity to continue their medical, psychiatric, or substance use disorder recovery immediately after exiting one of the following:

- Inpatient hospital
- Residential alcohol or drug use recovery or treatment facility
- Residential mental health treatment facility
- Correctional facility
- Nursing facility
- Recuperative care

One-time lifetime benefit and not to exceed duration of six months.

**The member must be exiting one of the following:**

☐ Recuperative care

☐ Inpatient hospital stay

☐ Residential alcohol or drug abuse recovery or treatment facility

☐ Residential mental health treatment facility

☐ Correctional facility

**The member must meet at least one of the following criteria and sub criterion when indicated:**

**The member meets the HUD definition of homeless:** ☐ Yes ☐ No

The member must meet one or more in both sections to be eligible:

☐ Primary nighttime residence is not meant for human habitation

☐ Lives in a temporary shelter (hotel, motel, congregate shelter, transitional housing, paid for by a local, state, or federal program)

☐ Is exiting an institution where member resided for 90 days or less and resided in an emergency shelter or place not meant for human habitation immediately before entering

☐ An individual or family who received written notice to vacate their residency within 14 days since the date they applied for CS and has not identified subsequent housing and does not have the resources or support needed to obtain other permanent housing

☐ An individual or family who is fleeing, or attempting to flee domestic violence, has no other residence, and lacks the resources or networks needed to obtain other permanent housing and meets at least one:

☐ Enrolled in ECM

☐ Has one or more chronic conditions

☐ Has a serious mental illness

☐ Is at risk of institutionalization or requiring residential services due to substance use disorder

☐ **Short-term post hospitalization housing**

**The member is at risk of homelessness:** ☐ Yes ☐ No

☐ Meets HUD's definition of at risk of homelessness, has an income below 30% of the area median family income, and does not have sufficient resources or support networks (such as family, friends, faith-based, or other social networks) to prevent them from moving into an emergency shelter or another place described as homeless and meets at least one:

☐ Has moved two or more times in the last 60 days due to economic reasons.

☐ Is living in someone else's home due to economic hardship

☐ Received written notice to vacate their home within 21 days since the day they applied for CS

☐ Lives in a hotel or motel and cost is not paid for by a local, state, or federal organization

☐ Is exiting a publicly funded institution or system of care

☐ Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, **as identified in the recipient's approved Con Plan.**

**Members at risk of homelessness must also meet at least one of the following:**

☐ One or more serious chronic conditions

☐ One or more serious mental illness

☐ At risk of institutionalization, overdose, or requiring services due to SUD, or has a serious emotional disturbance (children and adolescents)

☐ Enrolled in ECM

☐ Transition-age youth with significant barriers to housing instability (such as conviction(s), history of foster care, involvement with the juvenile justice or criminal justice system, serious mental illness, serious emotional disturbance, survivor of human trafficking or domestic violence)

**Child or youth experiencing homelessness: The member is child or youth that does not qualify as homeless under this section but qualifies as homeless ☐ Yes ☐ No under:**

☐ *Runaway and Homeless Youth Act* 42 U.S.C. 2732a – Section 387: Under 18 and it is not safe to live at home and has no other safe alternative living arrangement.

☐ *Head Start Act* 42 U.S.C. 9832 – Section 637: Sharing housing with others due to economic hardship, emergency shelters, or living in places not meant for human habitation, or other unsafe housing conditions (including migrant children and youth).

☐ *Violence Against Women Act* 42 U.S.C. 14043E-2: Sharing housing with others due to economic hardship, living in an emergency shelter or similar, or living in a place not meant for human habitation.

☐ *Public Health Service Act* 42 U.S.C. 254(h) – Section 330 (h): Lacks housing, includes if primary nighttime residence is a supervised public or private facility that provides temporary accommodations, or in transitional housing.

**☐ Short-term post hospitalization housing**

☐ *Food and Nutrition Act of 2008* 7 U.S.C. 2012 – Section 3: Lacks a fixed and regular nighttime residence or is part of a nighttime residence that is a publicly or privately operated shelter, an institution that provides temporary residence for individuals intended to be institutionalized, or in a temporary accommodation (not more than 90 days) or lives in a place not meant for regular sleeping for human beings.

**Child or youth experiencing homelessness and their parent(s) or guardian(s):** The member is a child or youth, and their parent(s) or guardian(s), who does not qualify as homeless under this section but qualifies as homeless under:

☐ *McKinney-Vento Homeless Assistance Act* 42 U.S.C. 11434a – Section 725: Meets the definition of homeless under HUD or other federal statutes. Has experienced a long-term period without living independently in permanent housing, or experienced persistent instability, or can be expected to continue in such a status for an extended period of time due to chronic disabilities, physical or mental health conditions, dependency, history of domestic violence or child abuse, the presence of a child/youth with a disability, or multiple barriers to employment.

**Additional comments:**

**If the member has already been admitted to a recuperative care facility, include the following information:**

Facility name:

Facility NPI:

Date of admission:

**Is the member currently receiving housing navigation services?** ☐ Yes ☐ No

**☐ Respite services**

Respite services for non-paid caregivers of members only. Provided on a short-term basis due to the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. Services can be provided in the home or a facility.

**Requesting urgent/expedited review?** ☐ Yes ☐ No

**The member:**

☐ Resides in the community

☐ Requires assistance with activities of daily living

☐ Is dependent on non-paid caregivers

☐ Faces housing insecurity or has housing that would jeopardize his or her health and safety without modification

**For expedited processing, please complete and submit the Personal Care & Homemaker and Respite Services Questionnaire on pgs. 13 to 16.**

☐ Respite services

Documentation

We require you to upload one or more of the following documents with this request:

- If respite is due to member needs, a MD order including dx, medical need, and evidence of frailty is required.
- Documentation of any support agencies providing any care to the member
- Documentation from support agencies indicating services/supports member needs or receives

If care is needed due to unpaid caregiver needs, an attestation that the unpaid caregiver can confirm the reason for a need for service due to medical episode is required. No personal health information is needed.