Community Supports Member Referral Form

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

Community Supports (CS) services help improve the health and well-being of managed care plan (MCP) members by addressing health-related social needs. These services support members in living healthier lives. They may help prevent the future need for higher-cost, more intensive care — including hospital admissions, skilled nursing facility stays, discharge delays, or emergency department visits.

CS services are provided by contracted, community-based care providers to members who have been approved for the program. To be eligible for the following services, members must meet specific criteria described in sections one through 13 of this form:

1. Medically tailored meals/medically supportive food
2. Housing transition navigation services
3. Housing tenancy and sustaining services
4. Housing deposit services
5. Assisted living facility (ALF) transitions
6. Community or home transition services
7. Environmental accessibility adaptations (EAA) (also known as home modifications)
8. Asthma remediation services (also known as asthma trigger remediations)
9. Day habilitation
10. Personal care and homemaker services
11. Recuperative care or medical respite care
12. Short-term post-hospitalization housing
13. Respite services

Note: After providing the required information about the referral source and member, please complete the applicable section(s) below for each requested service.

Submit the referral form by:

- Secure email: CalAIMReferrals@anthem.com
- Fax: **877-734-1857**
- Contracted care providers to refer via provider website/Care Central

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Call Medi-Cal Customer Care Center at:

- **800-407-4627** (TTY 711) (outside L.A. County)
- **888-285-7801** (TTY 711) (inside L.A. County)

Referral source information

Referral source information	
Date of referral*:	
Type of referral*:	☐ Routine ☐ Expedited
External referral by (select one)*:	☐ Medical provider (choose the best option) ☐ Hospital ☐ Primary care provider (PMG, clinic, or PCP) ☐ Behavioral health provider ☐ Social Services provider ☐ Other ☐ Member/caregiver ☐ Corrections facility ☐ ECM provider ☐ CS provider ☐ Other medical or social service care provider
Referring individual name*:	
Referring individual's relationship with the member*:	
Referring organization name*:	
Referring organization NPI:	
Referrer phone number*:	
Referrer fax number:	
Referrer email address*:	
Member provides consent for the requested services:	☐ Yes ☐ No
☐ 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, including dates, times,	

Referral source information
signatures, voice capture, or phone records, which will be required during any prospective audit.
Note to referrers: Please only mark the services you are referring to.

Member information

Member information:	
Member first name*:	
Member last name*:	
Member Medi-Cal Managed Care client ID # (CIN):	
Member's managed care plan:	
Member DOB (MM/DD/YYYY)*:	
Member residential address: ☐ Please mark here for: No fixed current address. If available, please list the Member's frequently visited location.	
Member residential city:	
Member residential ZIP code:	
Member's primary phone number*:	
Best time to contact:	
Member preferred name:	
Member preferred language:	
Member email:	
Best contact method for member/caregiver, if applicable:	☐ Phone ☐ Email
Best contact time for member/caregiver:	
Parent/guardian/caregiver name, if applicable:	
Parent/guardian/caregiver phone number, if available:	
Parent/guardian/caregiver email, if available:	
Care manager name:	
Care manager contact information:	

Member information:	
Member's primary care provider name:	

Section 1: Medically tailored meals/medically supportive food

☐ Medically tailored meals/medically supportive food
This service offers up to two meals per day and/or medically supportive food (such as a weekly voucher), along with nutrition services for up to 12 weeks or longer if medically necessary. Meals or food are not provided solely to address food insecurity. Exclusions: If the member receives other meal-delivery services or weekly vouchers from local, state, or federally funded programs, 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 nutrition-sensitive chronic conditions:
☐ Diabetes ☐ Congestive heart failure ☐ Chronic kidney disease ☐ Chronic lung disorders ☐ Human immunodeficiency virus (HIV) ☐ Cancer ☐ Gestational diabetes, or other high-risk perinatal conditions ☐ Chronic or disabling mental/behavioral health disorders ☐ Other
If the member is ECM enrolled, provide the ECM provider name/contact:
Type of MTM/MSF: ☐ Prefers meal deliveries ☐ Prefers supportive food/box ☐ Prefers voucher ☐ Other _____
If CS services have begun, indicate the service start date:

☐ Medically tailored meals/medically supportive food
Documentation: We recommend you upload one or more of the following documents with this request:
• Documentation/office visit notes with diagnosis or identification of chronic illness requiring a special diet • Skilled nursing discharge plan • Documentation from support agencies indicating services/supports the member needs or receives • Emergency department, inpatient, skilled nursing discharge paperwork • Medication/treatment orders

Section 2: Housing transition navigation services

☐ Housing transition navigation services	
I acknowledge that this request does not cover room and board. This service includes tenant screening, housing assessment, a housing support plan, help with searching for housing, assistance with securing housing (applications/documentation), benefit advocacy, finding and securing resources for rent subsidy and expenses, supporting reasonable accommodations, landlord education and engagement, ensuring a safe living environment and move-in readiness, advocacy with landlords, move-in support, a housing crisis support plan, transportation resources, and environmental modifications as needed. ☐ By marking this box, you are attesting that all information provided in this section is true and accurate.	
The member must meet at least one of the following criteria and sub-criterion when indicated	
1. Social and Clinical Risk: a. Social Risk: The member meets the HUD homeless definition or the HUD at-risk of homelessness definition (with 3 DHCS modifications – refer to DHCS CS Policy Guide Volume 2) AND b. Clinical Risk: Member must have one or more of the following: i. Meets the access criteria for Medi-Cal Specialty Mental Health Services ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System iii. One or more serious chronic physical health conditions; iv. One or more physical, intellectual, or developmental disabilities; or	☐ Yes ☐ No

☐ Housing transition navigation services	
v. Individuals who are pregnant up through 12 months postpartum	
2. Member is determined eligible and authorized for Transitional Rent.	☐ Yes ☐ No
3. Member is prioritized for a permanent supportive housing unit or rental financial assistance (subsidy) through the Coordinated Entry System (CES) or a similar system designed to identify highly vulnerable people with disabilities, one or more serious chronic conditions, serious mental illness, institutionalization, or those requiring residential services due to a substance use disorder. This also includes people exiting incarceration.	☐ Yes ☐ No
Additional comments:	
If CS services have begun, indicate the service start date:	
Documentation: We recommend you upload one or more of the following documents with this request:	
• Documentation of homelessness or at risk of homelessness by service care providers, PCPs, specialists, or outreach care providers • Documentation of entries/exits from shelters • Notices from the current landlord • Financial statements	

Section 3: Housing tenancy and sustaining services

☐ Housing tenancy and sustaining services	
Services are designed to maintain a safe and stable tenancy once housing is secured. These services may include identifying and addressing behaviors that threaten housing stability, providing education on the roles, rights, and responsibilities of tenants and landlords, coaching on managing and developing relationships with landlords and property managers, helping resolve landlord or neighbor disputes, advocating and connecting clients to community resources, assisting with benefits advocacy, and supporting annual housing recertification processes (review, update, or modify).	
The member must meet at least one of the following criteria and sub-criterion when indicated:	
1. Social and Clinical Risk: a. Social Risk: The member meets the HUD homeless definition or the HUD at-risk of homelessness definition (with 3 DHCS modifications – refer to DHCS CS Policy Guide Volume 2) AND b. Clinical Risk: Member must have one or more of the following: i. Meets the access criteria for Medi-Cal Specialty Mental Health Services ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System iii. One or more serious chronic physical health conditions; iv. One or more physical, intellectual, or developmental disabilities; or v. Individuals who are pregnant up through 12 months postpartum	☐ Yes ☐ No
2. Member is determined eligible and authorized for Transitional Rent.	☐ Yes ☐ No
3. Member is prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System 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	☐ Yes ☐ No

☐ Housing tenancy and sustaining services
Additional comments:
If CS services have begun, indicate the service start date:
Documentation: We require you to upload one or more of the following documents with this request:
• Housing support plan • Lease agreements • Financial statements

Section 4: Housing deposit services

☐ Housing deposit services
Identification, coordination, securing, or funding of one-time services and modifications necessary to help the member establish a basic household. Funding can support security deposits, utility setup fees/deposits, services needed for the member's health and safety, goods or medically necessary adaptive aids to maintain their health and safety at home, and essential household items for moving in. Does not cover rental assistance or rent in arrears. Housing deposits are available once per waiver period, with a maximum of $5,000. If a member does not have an individualized housing support plan, refer to Housing Transition Navigation first.
The member must meet at least one of the following criteria and sub-criterion when indicated:

☐ Housing deposit services	
1. Social and Clinical Risk: a. Social Risk: The member meets the HUD homeless definition or the HUD at-risk of homelessness definition (with 3 DHCS modifications – refer to DHCS CS Policy Guide Volume 2) AND b. Clinical Risk: Member must have one or more of the following: i. Meets the access criteria for Medi-Cal Specialty Mental Health Services ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System iii. One or more serious chronic physical health conditions; iv. One or more physical, intellectual, or developmental disabilities; or v. Individuals who are pregnant up through 12 months postpartum	☐ Yes ☐ No
2. Member is determined eligible and authorized for Transitional Rent.	☐ Yes ☐ No
3. Member is prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System 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.	☐ Yes ☐ No
Members must meet all of the following to be considered for housing deposits:	
☐ The member attests that they have not used this service since 1/1/2022. ☐ The referring party attests that the member has been informed of additional information and resources regarding housing vouchers. ☐ The member has an Individualized Housing Support Plan, which is included with the referral.	
Basic household item expenses are capped at $1,000 for the primary member requesting authorization. An additional $500 per household member (defined as spouse, domestic partner, or dependent) may be authorized. Request for home goods must be submitted within 30 days of the member's move-in date. Household size:	

☐ Housing deposit services

☐ Permanent Housing Attestation (for contracted care providers only):
Contracted provider attests to member potential for permanent housing. Requests for housing deposit funds for eligible items. Provider will hold supporting documentation (receipts for purchased/paid items) requested on the members' behalf. Authorization for $5,000 to include eligible items only. Final claims submission for actual cost not to exceed $5,000.

- Application fee/s
- Security deposits are required to obtain a lease on an apartment or home
- Set-up fees/deposits for utilities, or for utilities or services in arrears (limited to 3 months)
- First month’s coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water
- Goods such as an air conditioner or heater, and other medically necessary adaptive aides and services, designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, that are necessary to ensure access and safety for the individual upon moving into the home.
- Basic Household items to include the following:
- Kitchen items: plates, bowls, utensils, cups, pots, pans, dining table, and chairs
  - Bedroom: mattress, bedframe, boxspring, mattress protector, bedding, crib/bassinet
  - Miscellaneous: towels, cleaning supplies, vacuum, broom

Documentation:
Noncontracted care providers must include at least one of the following documents with this request. For contracted care providers, any of these may be requested:

- Lease agreements or signed documentation from the lessor indicating the required move-in cost, including line-item costs and the total amount. It must match what the actual lease agreement states once available.
- Utility bill/deposit agreement
- Updated housing support plan showing members' current goals
- The W-9 form of the payee, including current contact information and address to which payment will be sent. If requesting payment by automatic clearing house (ACH) or direct deposit, bank information and a voided check will be required.
- Financial statements, or an 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).

Section 5: Assisted Living Facility (ALF) transitions

☐ Assisted Living Facility (ALF) transitions	
Choose option one or option two.	
☐ **Option one: Nursing facility transition to ALF** This service is for people transitioning from a licensed healthcare facility to a living arrangement in a Residential Care Facility for the Elderly (RCFE) or/and Adult Residential Facility (ARF).	
Is the member currently residing in a nursing facility and receiving medically necessary nursing facility services?	☐ Yes ☐ No
Have they lived 60 + days in a nursing facility?	☐ Yes ☐ No ☐ Unknown
Are they willing to live in an Assisted Living Facility with appropriate and cost-effective supports and services?	☐ Yes ☐ No
Are they able to pay for their own living expenses?	☐ Yes ☐ No ☐ Unknown
☐ **Option two: Nursing Facility Diversion to ALF** This service is designed for community members who are at risk of needing nursing facility care in the near future and are willing to reside in an assisted living facility rather than a long-term nursing home placement.	
Is the member interested in remaining in the community?	☐ Yes ☐ No
Does the member meet the minimum criteria to receive nursing facility LOC services and, instead of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF?	☐ Yes ☐ No
Is the member willing and 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:	
• ED, inpatient, skilled nursing paperwork • Documentation/notes/medical records from PCP • Assessments for fall risk, cognition, ADLs, and IADLs	

☐ Assisted Living Facility (ALF) transitions
• Medication/treatment orders

Section 6: Community or home transition services

☐ Community or home transition services	
Non-recurring setup expenses for members transitioning from a licensed facility to living in a private residence, where the member is directly responsible for their own living costs.	
Is the member currently receiving medically necessary nursing facility level of care (LOC) services, and instead of remaining in the nursing facility or Recuperative Care setting, is the member choosing to transition home and continue to receive medically necessary nursing facility LOC services?	☐ Yes ☐ No
Have they lived 60+ days in a nursing home and/or recuperative care setting?	☐ Yes ☐ No
Are they able to reside safely in the community with appropriate and cost-effective supports and services?	☐ 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:	
• ED, inpatient, skilled nursing discharge paperwork • Assessments for fall risk, cognition, ADLs, and IADLs • Documentation/notes/medical records from PCP • Documentation of home modifications/services completed	

Section 7: Environmental accessibility adaptations (EAA), also known as home modifications

☐ Environmental accessibility adaptations (EAA), also known as home modifications:	
Physical adaptations to a home that are essential for ensuring a member's health, welfare, and safety, or that enable the member to function more independently at home, are crucial. Without these, the member might require institutional care. The 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

☐ Environmental accessibility adaptations (EAA), also known as home modifications:	
	☐ No
This request is for:	☐ Equipment ☐ Home modification ☐ Personal emergency response (PERS)
Documentation: We require you to 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 is required that explains how the modifications meet the member's medical needs. A brief, written evaluation specifically addressed to the member, describing how and why the modifications fulfill the member's needs, will still be necessary. • A home visit may have been conducted to determine the suitability of any requested modifications.	

Section 8: Asthma remediation services, also known as asthma trigger remediations

☐ 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 severe asthma attacks that could lead to emergency services and hospitalization. The lifetime cap is $7,500.

☐ Asthma remediation services, also known as asthma trigger remediations	
The member has poorly controlled asthma documented by: ☐ Emergency department visit ☐ Hospitalization ☐ Two sick/urgent care visits in the past 12 months ☐ Score of ≤ 19 on the asthma control test	
Is the home owned, leased, rented, or occupied by the member?	☐ Yes ☐ No
This request is for (mark all that apply):	☐ Equipment ☐ Home modification
Has the asthma preventive services home assessment been completed?	☐ Yes ☐ No
If CS services have begun, please indicate the service start date:	
Documentation: Please upload the following documents with this request:	
• Asthma Preventive Services (APS) home assessment	

Section 9: Day habilitation

☐ Day habilitation	
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.	
The member must meet at least one of the following criteria and sub-criterion when indicated:	
1. Social and Clinical Risk: a. Social Risk: The member meets the HUD homeless definition or the HUD at-risk of homelessness definition (with 3 DHCS modifications – refer to DHCS CS Policy Guide Volume 2) AND b. Clinical Risk: Member must have one or more of the following: i. Meets the access criteria for Medi-Cal Specialty Mental Health Services ii. Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System iii. One or more serious chronic physical health conditions;	☐ Yes ☐ No

☐ Day habilitation	
iv. One or more physical, intellectual, or developmental disabilities; or v. Individuals who are pregnant up through 12-months postpartum	
2. Member is determined eligible and authorized for Transitional Rent.	☐ Yes ☐ No
3. Member is prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System 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	☐ Yes ☐ No
The member must meet at least one of the following criteria ☐ Experiencing Homelessness OR ☐ Exited homelessness and entered housing in the last 24 months OR ☐ At risk of homelessness or institutionalization, and whose housing stability could be improved through participation in a day habilitation program	
If CS services have begun, indicate the service start date:	
Documentation: We recommend you upload one or more of the following documents with this request:	
• Documentation of housing status by service providers, PCP, specialists, or outreach providers • Documentation of participation in housing navigation or housing tenancy and sustaining services • Plan of care showing members' support needs, services to be provided, and frequency of support being requested	

Section 10: Personal care and homemaker services

☐ Personal care and homemaker services	
This service provides help with activities of daily living (ADLs) such as bathing, dressing, toileting, walking, and eating. It can also include support with instrumental activities of daily living (IADLs), such as meal preparation, grocery shopping, and managing finances. Homemaker or chore services involve tasks like cleaning, shopping, and laundry. This service supports members who would otherwise be unable to stay in their homes. Always try to use IHSS services first. Please ensure all questions in this section are answered.	
Requesting urgent/expedited review? ☐ Yes ☐ No	
The member must meet one of the two: ☐ At risk for hospitalization or institutionalization in a nursing facility. ☐ Member requires help with activities of daily living (ADL) and satisfies one of the four listed criteria.	
1. The member has applied for in-home supportive services (IHSS) and is pending approval	☐ Yes ☐ No
a. If **yes**, provide the IHSS referral date: b. If **no**, ensure the member applies before referring to Community Supports at cdss.ca.gov/in-home-supportive-services.	
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.	☐ Yes ☐ No
a. If **yes**, provide reassessment request date: b. IHSS hours per month:	
3. The member has been approved for the maximum number of IHSS hours (283 hours/month) but needs additional support.	☐ Yes ☐ No
4. The member is not eligible for IHSS and requires services to prevent a short-term stay in a skilled nursing facility (not to exceed 60 days). a. If **yes**, provide the IHSS Notice of Action, indicating denial if available:	☐ Yes ☐ No
Documentation: We require you to upload one or more of the following documents with this request:	
• Documentation/office visit notes with diagnosis and identification of frailty • Assessments identifying members' physical needs • Documentation from support agencies indicating services/supports the member needs or receives (this includes IHSS documents and IHSS Case ID number) • Physical therapy/durable medical equipment evaluation documenting safety needs • Medication/treatment orders	

☐ Personal care and homemaker services Questionnaire for Personal Care and Homemaker Services and Respite Services	
Please have the ECM provider, member, or caregiver complete the following questionnaire to expedite the request.	
On a scale of one to five, how much help does the member need with the following activities:	
Housework	Food shopping
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help
Other shopping and errands	Meal preparation
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help
Meal clean up	Bed/baths/bathing

☐ Personal care and homemaker services	
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help
Mobility inside/ambulation	Dressing
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help
Grooming	Bowel/bladder
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help
Repositioning	Transfer

☐ Personal care and homemaker services	
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help
Eating/feeding	Laundry
☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 5 = dependent, unable to complete without help	☐ 1 = no help needed ☐ 2 = very little help needed, a reminder to complete ☐ 3 = need someone to stand by and physically assist me some of the time ☐ 4 = need someone to assist me with tasks, and physically, most of the time ☐ 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:	
Who is completing the questionnaire?	
Name:	
Relationship to the member:	
Contact:	

Section 11: Recuperative care or medical respite care

☐ Recuperative care or medical respite care
Short-term residential care is for members who no longer need hospitalization but still need to recover from an injury or illness and whose condition could worsen in an unstable living environment. At a minimum, this service provides temporary housing with a bed and meals, along with ongoing monitoring of the member's medical or behavioral health condition. Available every 12 months, subject to the global cap: not to exceed duration of 182 days across Recuperative Care, Short-term Post-Hospitalization, and Transitional Rent: • If the member is homeless, consider requesting Housing Transition and Enhanced Case Management services at this time. • Contracted providers must verify global cap eligibility in Total Member View (TMV) prior to referring or admitting to recuperative care. If the global cap is not met, no preapproval is required for the initial seven days. 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 Find Care and search by zip code to find the nearest contracted recuperative care facility.
☐ Attestation that the contracted provider has confirmed the number of days member has available for room and board services subject to Global Cap. • Number of days remaining: _____ • Previous health plans in last 12 months: _____

The member must meet BOTH of the following criteria: 1. Member requires recovery in order to heal from an injury or illness AND 2. Experiencing or at risk of homelessness	☐ Yes ☐ No

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

Facility name:	
Facility NPI:	
Date of admission:	

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

☐ Recuperative care or medical respite care

- 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

Section 12: Short-term post-hospitalization housing

☐ 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

Members must have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care.

Available every 12 months, subject to the global cap: not to exceed the duration of 182 days across Recuperative Care, Short-term Post-Hospitalization, and Transitional Rent.

Contracted providers must verify global cap eligibility in Total Member View (TMV) prior to referring or admitting to short-term post-hospitalization. If the global cap is not met, no preapproval is required for initial seven days.

☐ Attestation that the contracted provider has confirmed the number of days member has available for room and board services subject to Global Cap.

- Number of days remaining: _____
- Previous health plans in last 12 months: _____

☐ Short-term post-hospitalization housing	
The member must be exiting one of the following: ☐ Recuperative care ☐ Inpatient hospital stay ☐ Residential alcohol or substance use recovery or treatment facility ☐ Residential mental health treatment facility ☐ Correctional facility	
Member must meet ALL of the following criteria	
1. Member is exiting an institution, which includes recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facility, or nursing facility AND 2. Experiencing or at risk of homelessness AND 3. Meeting one of the following criteria: a. Are receiving ECM b. Have one or more serious chronic conditions c. Have serious mental illness or d. Are at risk of institutionalization or requiring residential services as a result of a substance use disorder AND 4. Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing	☐ Yes ☐ No
Additional comments:	
If the member has already been admitted to a short-term post-hospitalization facility, include the following information:	
Facility name:	
Facility NPI:	
Date of admission:	
Is the member currently receiving housing navigation services?	☐ Yes ☐ No

☐ Short-term post-hospitalization housing
Documentation: We require you to upload one or more of the following documents with this request:
• Emergency department, inpatient, skilled nursing, or recuperative care 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 the services/supports the member needs • Documentation/office visit notes with diagnosis and identification of frailty • Assessment determining limitations in ADLs • Medication/treatment orders

Section 13: Respite services

☐ Respite services	
Respite services are available only to unpaid caregivers of members. These services are provided on a short-term basis when those who typically care for or supervise members need relief or are absent. Services can be offered either in the home or at 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 pages 19-21.	
Documentation: We require you to upload one or more of the following documents with this request:	

☐ Respite services

- If respite is due to member needs, an MD order including diagnosis, medical need, and evidence of frailty is required.
- If documentation of any support agencies providing any care to the member
- If documentation from support agencies indicates services/supports the member needs or receives.
- If care is needed due to an unpaid caregiver need, an attestation that the unpaid caregiver can confirm the reason for a need for service due to a medical episode is required. No personal health information is needed.