CalAIM Community Supports Referral Form

Member Name: ____ **CIN:** __________________________

Note: Member must be eligible with CalOptima Health.
Step 1: Please fill out all applicable information below and proceed to Steps 2 and 3.

Referral Information:

Referral Date: ________________________ Referred by: ____________________________________

Agency or Relationship to Member: ____

Referring Provider National Provider Identifier (NPI) (if applicable): ____________________________

Phone: _______________________ Fax: _____________________ Email: ______________________

Member Information:

Member Name: ____________________________ CIN: ________________________________

Member Date of Birth: _______________________ Primary Care Provider (PCP): ___________________

Phone: ___________________________ Email: ____

Member's Preferred Language: _______________________ Is Member Currently in Hospital? __________

Step 2. Mark the boxes for Community Supports the member is interested in receiving. The following pages provide additional eligibility information about Community Supports. **Please complete all required check boxes prior to submission.**

Step 3: Fax or mail the completed referral form and supporting documents to CalOptima Health if the member belongs to a health network other than Kaiser Permanente. Email or mail all Kaiser Permanente referrals directly to Kaiser Permanente.

CalOptima Health Community Supports Health Network Contact Information

Health Network	Customer Service Phone Number (for Members)	Referral Submission	Mailing Address
CalOptima Health Direct and Health Networks (Except Kaiser Permanente)	1-888-587-8088	Fax: 1-714-338-3145	CalOptima Health Attn: LTSS CalAIM P.O. Box 11033 Orange, CA 92856

Health Network	Customer Service Phone Number (for Members)	Referral Submission	Mailing Address
Kaiser Permanente	1-866-551-9619	Secure email: RegCareCoordCaseMgmt @kp.org	Kaiser Permanente Attention: Medi-Cal and State Programs (Second Floor) 393 E. Walnut St. Pasadena, CA 91188

Housing Services		
□	**Housing Transition Navigation Services** Assists members with obtaining housing and preparing for move-in.	**Select <u>one</u> that applies:** □ Member is homeless **<u>OR</u>** □ Member is at risk of homelessness with significant barriers to housing **<u>OR</u>** □ Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System
□	**Housing Deposit** Identifies, coordinates and funds move-in costs and services for a basic household, excluding room and board. Members must be receiving Housing Transition Navigation Services.	**Select all that apply:** □ Member is homeless or at risk of homelessness □ Member is receiving Housing Transition Navigation Services Enter name of housing navigation provider: ___________________ *(Additional documentation will be requested from this provider.)* □ Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System Received this service before? Yes □ No □ Unknown □
□	**Housing Tenancy and Sustaining Services** Provides education, coaching and support to maintain a safe and stable tenancy once housing is secured.	**Select all that apply:** □ Member is homeless □ Member has received Housing Transition Navigation Services Enter name of housing navigation provider: _______________________ *(Additional documentation will be requested from this provider.)* □ Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System Received this service before? Yes □ No □ Unknown □
□	**Day Habilitation** Assists members with self-help skills, socialization	**Select <u>one</u> that applies:** □ Member is homeless

	and adaptive skills needed to remain in their natural setting.	□ Member is at risk of homelessness or institutionalization □ Member left homelessness and entered housing in the past 24 months
Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission		
□	**Recuperative Care** Provides short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury, illness or mental health condition.	**Select one that applies:** ☐ Member is homeless or at risk of homelessness ☐ Member is at risk of hospitalization or is post-hospitalization ☐ Member lives alone with no formal supports *Please attach the Recuperative Care or STPHH Referral Form*
□	**Short-Term Post-Hospitalization Housing (STPHH)** Assists members with high medical or behavioral health needs with short-term housing after leaving the hospital, recovery facility, Recuperative Care or other facility.	**Select all that apply:** ☐ Member is homeless or at risk of homelessness **AND** ☐ Member is exiting Recuperative Care, inpatient hospital, residential substance use disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility *Please attach the Recuperative Care or STPHH Referral Form*
□	**Community Transition Service** Provides nursing facility transition to a home.	**Review the following eligibility criteria:** 1. Currently receiving medically necessary nursing facility Level of Care (LOC) services **and**, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; **and** 2. Has lived 60+ days in a nursing home or medical respite setting; **and** 3. Interested in moving back to the community; **and** 4. Able to reside safely in the community with appropriate and cost-effective supports and services. **Member meets ALL criteria in this section to qualify**: Yes □ No □ Received this service before? Yes □ No □ Unknown □
□	**A. Nursing Facility Transition to Assisted Living Facility** Transitions members from a nursing facility into a Residential Care Facility	**Review the following eligibility criteria:** 1. Has resided 60+ days in a nursing facility; **and** 2. Willing to live in an assisted living setting as an alternative to a nursing facility; **and**

	for Elderly or Adult Residential Facility.	3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports and services. **Member meets ALL criteria in this section to qualify: Yes □ No □** Received this service before? Yes □ No □ Unknown □
Services Provided in the Home		
□	**B. Nursing Facility <u>Diversion</u> to Assisted Living Facility** Transitions members who, without this support, would need to reside in a nursing facility and instead transitions them into a Residential Care Facility for Elderly or Adult Residential Facility.	**Review the following eligibility criteria:** ☐ Interested in remaining in the community; **and** ☐ Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; **and** ☐ Must be currently receiving medically necessary nursing facility LOC services or meet the minimum criteria to receive those services in an assisted living facility. **Member meets ALL criteria in this section to qualify: Yes □ No □** Received this service before? Yes □ No □ Unknown □
□	**Personal Care and Homemaker Services** Provides members who need help with activities of daily living (ADLs) with personal care and homemaker services.	**Select all that apply:** □ Member is at risk for hospitalization or institutionalization in a nursing facility □ Member has functional deficits and no adequate support system **<u>AND</u>** **Select <u>one</u> that applies:** □ Member is approved for In-Home Supportive Services (IHSS) **and** has made a request for an increase in hours that is still pending □ Member has applied for IHSS and is waiting to have the assessment completed Has a family member or friend interested in becoming a caregiver? Yes □ No □ Unknown □
□	**Medically Tailored Meals** Provides members with Medically Tailored Meals at home after discharge from a hospital or nursing home.	**Select all that apply:** □ Member is currently in the hospital or nursing facility and Medically Tailored Meals are a part of the discharge plan. *(This will trigger an expedited request.)* List the member's chronic conditions: ____ □ Member was recently discharged from the hospital or skilled nursing facility □ Member is at high risk of hospitalization or nursing facility placement

		□ Member has extensive care coordination needs. Yes □ No □ If yes, describe: Member on a special diet? □ Yes □ No If yes, describe: □ Member is receiving other meal delivery services from local, state or federally funded programs. □ Interested in pre-made Medically Tailored Meals □ Interested in Medically Tailored Grocery Boxes Has a fridge? □ Yes □ No
□	**Respite Services** Provides respite to caregivers of members who require intermittent temporary supervision. This service is distinct from medical respite or Recuperative Care and provides rest for the caregiver only. Limit is 336 hours per year.	**Answer all sections below:** In-Home Respite Services are provided to the member in his or her own home or another location being used as the home. ☐ Dependent on a qualified caregiver and without one, member would need to be in a nursing facility Member has specific dates and times for needing a respite caregiver: Dates: ____________________ Times: ____________________ Member has other services that provide a caregiver: ☐ In-Home Supportive Services (IHSS) ☐ Community-Based Adult Services (CBAS) ☐ Regional Center ☐ Private Caregiver
□	**Environmental Accessibility Adaptations** Provides physical adaptations to a home that are necessary to ensure the health, welfare and safety of members, or that enable members to remain in their home.	Request for a Personal Emergency Response System (PERS)? Yes □ No □ **Select all that apply:** ☐ Member at risk for institutionalization in a nursing facility **AND** ☐ Member has discussed needing a home modification with Primary Care Provider (PCP) ☐ PCP has documented medical need for this service and will provide documentation upon request Received this service before? Yes □ No □ Unknown □

☐	**Asthma Remediation** Provides information for members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and provides needed equipment.	**Select all that apply:** ☐ Member had Emergency department visit or hospitalization in the past 12 months ☐ Member had two sick or urgent care visits in the past 12 months ☐ Member has a score of 19 or lower on the Asthma Control Test **AND** ☐ PCP has documented medical need for this service and will provide documentation upon request Received this service before? Yes ☐ No ☐ Unknown ☐