# Kern Family Health Care Referral Form

**Member Name:** _____ **CIN:** _____

**Note:** Member must be eligible with Kern Family Health Care
**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: _____

Agency Address, City, State, Zip : _____

Provider Tax ID number: _____ (for internal purposes only)

Referring Provider National Provider Identifier (NPI): _____

Phone: _____ Fax: _____ Email: _____

**Member Information:**

Member Name: _____CIN (if applicable): _____

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 Kern Family Health Care.

**Kern Family Health Care Supports Health Network Contact Information**

| Health Network | Customer Service Phone Number (for Members) | Referral Submission | Mailing Address |
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| **Kern Family Health Care (Except Kaiser Permanente)** | 661-632-1590 Option 6 | Fax: 661-473-7599 Or email: cssteam@khs-net.com | Kern Family Health Care 2900 Buck Owens Blvd Bakersfield, CA 93309 |

| Housing Services | | |
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| ☐ | **Housing Transition Navigation Services**<br>Assists members with obtaining housing and preparing for move-in. | **Select <u>one</u> that applies:**<br>□ Is the member experiencing homeless or at risk of homelessness?<br>☐ Yes<br>☐ No<br><br>**One of the following must also be yes**<br><br>□ Does the member have a current eviction notice?<br>□ Is the member being asked to leave their current living situation (ie. coach surfing)?<br>□ Does the member reside in a hotel or motel that is paid by a charitable organization?<br>□ Does the member suffer from any of the following<br>□ serious chronic condition<br>□ mental illness<br>□ substance abuse<br><br>**And**<br><br>□ Receiving Enhance Care Management (ECM)<br><br>□ Does the member have any children or other adults in the home? |
| ☐ | **Housing Deposit**<br>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:**<br>□ Member is homeless or at risk of homelessness<br>□ Member is receiving Housing Transition Navigation Services<br>Enter name of housing navigation provider: _____<br>*(Additional documentation will be requested from this provider.)*<br>□ Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System<br>Received this service before? Yes □ No □ Unknown ■ |

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| ☐ | **Housing Tenancy and Sustaining Services**<br>Provides education, coaching and support to maintain a safe and stable tenancy once housing is secured. | **Select all that apply:**<br>□ Member is homeless<br>□ Member has received Housing Transition Navigation Services<br>Enter name of housing navigation provider:<br>_____<br>*(Additional documentation will be requested from this provider.)*<br>□ Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System<br>Received this service before? Yes □ No □ Unknown □ |

| **Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission** | | |
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| ☐ | **Recuperative Care**<br>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 <u>one</u> that applies:**<br>☐ Member is homeless or at risk of homelessness<br>☐ Member is at risk of hospitalization or is post-hospitalization<br>☐ Member lives alone with no formal supports<br>*<u>When possible, please submit discharge summary/documents.</u>* |
| ☐ | **Short-Term Post-Hospitalization Housing (STPHH)**<br>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:**<br>☐ Member is homeless or at risk of homelessness<br>**<u>AND</u>**<br>☐ Member is exiting Recuperative Care, inpatient hospital, residential substance use disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility<br>*<u>When possible, please submit discharge summary/documents.</u>* |

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| ☐ | **Community Transition Service**<br>Provides nursing facility transition to a home. | **Review the following eligibility criteria:**<br>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**<br>2. Has lived 60+ days in a nursing home or medical respite setting; **and**<br>3. Interested in moving back to the community; **and**<br>4. Able to reside safely in the community with appropriate and cost-effective supports and services.<br>**Member meets ALL criteria in this section to qualify**: Yes □ No □<br>Received this service before? Yes □ No □ Unknown □ |
| ☐ | **A. Nursing Facility <u>Transition</u> to Assisted Living Facility**<br>Transitions members from a nursing facility into a Residential Care Facility | **Review the following eligibility criteria:**<br>1. Has resided 60+ days in a nursing facility; **and**<br>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.<br>**Member meets ALL criteria in this section to qualify: Yes □ No □**<br>Received this service before? Yes □ No □ Unknown □ |
| | **Services Provided in the Home** | |
| ☐ | **B. Nursing Facility <u>Diversion</u> to Assisted Living Facility**<br>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:**<br>☐ Interested in remaining in the community; **and**<br>☐ Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; **and**<br>☐ Must be currently receiving medically necessary nursing facility LOC services or meet the minimum criteria to receive those services in an assisted living facility.<br>**Member meets ALL criteria in this section to qualify: Yes □ No □**<br>Received this service before? Yes □ No □ Unknown □ |

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| ☐ | **Personal Care and Homemaker Services**<br><br>Provides members who need help with activities of daily living (ADLs) with personal care and homemaker services. | **Select all that apply:**<br><br>□ Member is at risk for hospitalization or institutionalization in a nursing facility<br><br>□ Member has functional deficits and no adequate support system<br><br>**AND**<br><br>**Select one that applies:**<br>□ Member is approved for In-Home Supportive Services (IHSS) **and** has made a request for an increase in hours that is still pending<br><br>□ Member has applied for IHSS and is waiting to have the assessment completed<br><br>Has a family member or friend interested in becoming a caregiver?<br><br>Yes □ No □ Unknown □ |
| ☐ | **Medically Tailored Meals**<br><br>Provides members with Medically Tailored Meals at home after discharge from a hospital or nursing home. | **Select all that apply:**<br>□ Does the member have a chronic condition, such as<br>□ Diabetes<br>□ Cardiovascular disorder<br>□ Congestive heart failure<br>□ Stroke<br>□ Chronic lunch disorders<br>□ Human Immunodeficiency virus<br>□ Gestational Diabetes<br>□ High risk perinatal conditions<br>□ Other: (fill in if possible)<br><br>OR<br>□ Disabling mental/behavioral health disorders<br>OR<br>□ Has the member been discharged from the hospital or skilled nursing facility or high risk of hospitalization?<br>OR<br>□ Does the member have extensive care coordination needs? |

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| ☐ | **Respite Services**<br><br>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.<br><br>Limit is 336 hours per year. | **Answer all sections below:**<br>In-Home Respite Services are provided to the member in his or her own home or another location being used as the home.<br><br>☐ Dependent on a qualified caregiver and without one, member would need to be in a nursing facility<br><br>Member has specific dates and times for needing a respite caregiver:<br><br>Dates: _____<br>Times:<br><br>Member has other services that provide a caregiver:<br>☐ In-Home Supportive Services (IHSS)<br>☐ Community-Based Adult Services (CBAS)<br>☐ Regional Center<br>☐ Private Caregiver |
| ☐ | **Asthma Remediation**<br><br>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:**<br><br>☐ Member had Emergency department visit or hospitalization in the past 12 months<br><br>☐ Member had two sick or urgent care visits in the past 12 months<br><br>☐ Member has a score of 19 or lower on the Asthma Control Test<br><br>**AND**<br><br>☐ PCP has documented medical need for this service and will provide documentation upon request<br><br>Received this service before? Yes □ No □ Unknown □ |