Kern Family Health Care®

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 or KFHC Member ID: _____

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. **All checkboxes must be completed prior to submission. Please include all necessary documentation with the referral.**
Incomplete submissions or missing documentation may result in processing delays.

Step 3: Fax, e-mail, or mail the completed referral form and supporting documents to Kern Family Health Care.

Kern Family Health Care-Community Supports Contact Information

Health Network	Customer Service Phone Number (for Members)	Referral Submission	Mailing Address
Kern Family Health Care	1-800-391-2000 Option 6	Fax: 661-473-7599 or email: cssteam@khs-net.com	Kern Family Health Care 2900 Buck Owens Blvd Bakersfield, CA 93309

Support For Housing Insecurities 		
■	**Housing Transition Navigation Services** Assists members with obtaining housing and preparing for move-in.	Is the member experiencing homelessness or at risk of homelessness? **Select <u>one</u>:** ◘ Experiencing Homelessness. ◘ At Risk of Homelessness. ◘ None of the Above. If <u>experiencing homelessness</u>, **identify the homeless category that applies:** ■ The member lacks a fixed, regular and adequate night-time residence. ■ The member lacks living in a place not meant for human habitation (e.g., streets, cars, encampments). ■ The member is living in an emergency shelter, transitional housing, or exiting an institution (e.g., jail, hospital) withing the last 90 days and were homeless before entering. If at <u>risk of homelessness</u>, **select what applies:** ■ The member will lose primary night-time residence within 14 days. **(eviction notice or pay or quit notice/documentation required)** ■ The member is fleeing or attempting to flee a domestic violence, dating violence, sexual assault, stalking, or other dangerous/life- threatening conditions. (**provide police report or letter from supportive services)** ■ The member is a youth under the age of 25 who has not had stable housing in the past 60 days. **AND** Does the member have one of the following clinical risk factors? **Select <u>all</u> that applies:** ■ The member currently receives specialty mental health services. (e.g., Kern Behavioral Health and Recovery Services) ■ The member has one or more serious chronic physical health conditions. ■ The member has been diagnosed with a physical, intellectual or disabling condition. ■ The member is pregnant or is up to 12 months postpartum. ■ None of the Above.

■	**Housing Deposit** Identifies, coordinates and funds move-in costs and services for essential household items, excluding room and board. Members must be receiving Housing Transition Navigation Services.	Is or has the member received Housing Transition/Navigation Services? Yes ◘ No ◘ If yes, does the member have a housing plan? **(required to receive this service)** Yes ◘ No ◘ Is the member experiencing homelessness or at risk of becoming homeless? **Select <u>one</u>:** ◘ Experiencing homelessness ◘ At risk of homelessness ◘ None of the above If <u>experience homelessness</u>, (**select all that apply**): ■ The member lacks a fixed, regular and adequate nighttime residence ■ The member is living in a place not meant for human habitation (e.g., streets, cars, encampments) ■ The member is living in an emergency shelter, transitional housing, or exiting an institution (e.g., jail, hospital) within the last 90 days and were homeless before entering ■ The member is currently prioritized for permanent supporting housing If <u>at risk of homelessness</u>, (**select all that apply**): ■ The member will lose primary nighttime residence within 14 days. **(Eviction notice or pay or quit notice/documentation required)** ■ The member is fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous/life-threatening conditions. **(Provide police report or letter from supportive services.)** ■ The member is a youth under the age of 25 who has not had stable housing in the past 60 days.

■	**Housing Tenancy and Sustaining Services** Provides education, coaching and support to maintain a safe and stable tenancy once housing is secured.	Is or has the member received Housing Transition/Navigation Services? Yes ◘ No ◘ Is the member experiencing homelessness or at risk of becoming homeless? **Select <u>one</u>:** ◘ Experiencing homelessness ◘ At risk of homelessness ◘ None of the above If <u>experience homelessness</u>, (**select all that apply**): ■ The member lacks a fixed, regular and adequate night-time residence. ■ The member is living in a place not meant for human habitation (e.g., streets, cars, encampments). ■ The member is living in an emergency shelter, transitional housing, or exiting an institution (e.g., jail, hospital) within the last 90 days and were homeless before entering. ■ The member is currently prioritized for permanent supporting housing. If <u>at risk of homelessness</u>, (**select all that apply**): ■ The member will lose primary nighttime residence within 14 days **(Eviction notice or pay or quit notice/documentation required)** ■ The member is fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous/life-threatening conditions. **(Provide police report or letter from supportive services.)** ■ The member is a youth under the age of 25 who has not had stable housing in the past 60 days. **AND** Does the member have one of the following risk factors? **Select <u>all</u> that apply**: ■ The member currently receives specialty mental health. services (e.g. Kern Behavioral Health and Recovery Services). ■ The member has one or more serious chronic physical health conditions. ■ The member has been diagnosed with a physical, intellectual or disabling condition. ■ The member is pregnant or is up to 12 months postpartum. ■ None of the above

■	**Day Habilitation** The program aims to support the Member in developing, maintaining and enhancing self-help, socialization, and adaptive abilities.	Is the member experiencing homelessness? Yes ◘ No ◘ If yes, select the current situation (**select <u>one</u>):** ◘ The member is living in a place not meant for human habitation (e.g., streets, cars, encampments). ◘ The member is living in an emergency shelter, transitional housing, or exiting an institution (e.g., jail, hospital) within the last 90 days and were homeless before entering. If no, is the member at risk of homelessness or institutionalization? Yes ◘ No ◘ If yes, **select <u>all</u> that apply**: ■ The member will lose primary night-time residence within 14 days. ■ The member will have no subsequent residence has been identified. ■ The member lacks the resources or support networks to obtain housing. Has the member exited homelessness and entered housing in the last 24 months? Yes ◘ No ◘

Support for Post-Acute Care Admission or Post-Nursing Facility Admission 		
■	**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.	Has the member been recently discharged or is being discharged from a hospital or institution? Yes ◘ No ◘ If yes, select the facility type and include the discharge date (**MM/DD/YYYY**). ◘ Recuperative Care _____ ◘ Hospital _____ ◘ Psychiatric facility _____ ◘ Nursing facility _____ ◘ Residential Treatment Center _____ **AND** Is the member experiencing or at risk of homelessness? Yes ◘ No ◘

		Please s**elect <u>all</u> that apply:** ■ Is the member receiving ECM services. ■ Is the member diagnosed with 1 or more serious chronic conditions. ■ Is the member diagnosed with a serious mental illness. ■ Is the member at risk of institutionalization or requiring residential services as a result of a substance use disorder. ■ None of the above Does the member have ongoing physical or mental health needs that would require continued institutional care if not in a short-term post hospitalization setting? Yes ▣ No ▣

■	**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.	Has the member recently been discharged from the hospital? Yes ▣ No ▣ If yes, include the hospital name and discharge date: _____ Hospital Name _____ Discharge Date (MM/DD/YYYY) Is the member recovering from a physical illness, injury, or surgery that still requires medical oversight? Yes ▣ No ▣ If yes, is the member experiencing or at risk of homelessness? Yes ▣ No ▣

■	**Assisted Living Facility (ALF) Transitions** Transitions members who, without this support, would need to reside in a nursing facility and instead transition them into a Residential Care Facility for Elderly or Adult Residential Facility.	Is the member residing in a Nursing Facility or Community/Home? (**select one):** ■ Nursing Facility ■ Community or Home **If Nursing Facility is selected:** Has the member resided 60+ days in a nursing facility? Yes ■ No ■ **AND** Is the member willing to live in an assisted living setting as an alternative to a nursing facility? Yes ■ No ■ **AND** Is the member able to reside safely in an assisted living facility with appropriate and cost-effective support? Yes ■ No ■ **If Community or Home is selected:** Is the member interested in remaining in the community? Yes ■ No ■ **AND** Is the member willing and able to reside safely in an assisted living facility? Yes ■ No ■ **AND** Does the member meet the minimum criteria to receive nursing facility Level of Care (LOC) services? Yes ■ No ■

■	**Community or Home Transition Services** Provides nursing facility transition to a home.	Does the member receive assistance from the California Community Transition (CCT) program? Yes ■ No ■ If no, does the member receive assistance from Home and Community Based Alternative (HCBA) Waiver? Yes ■ No ■ If no, does the member receive assistance from the Multipurpose Senior Services Program (MSSP)? Yes ■ No ■ If no, where is the member currently residing? ■ Nursing Facility ■ Recuperative Care ■ None of the Above Is the member currently receiving medically necessary nursing facility Level of Care (LOC)? Yes ■ No ■ **AND** Has the member resided 60+ days in a nursing home or recuperative care setting? Yes ■ No ■ **AND** Is the member interested in moving back to the community? Yes ■ No ■ **AND** Is the member able to reside safely in the community with appropriate and cost-effective support and services? Yes ■ No ■ Is the member able to pay for their own monthly or mortgage expenses? Yes ■ No ■

Support for Members in the Home		
■	**Personal Care and Homemaker Services** Provides members who need help with activities of daily living (ADLs) with personal care and homemaker services.	Is the member currently in or receiving any of the services below? ■ Long Term Care Facility ■ Assisted Living Facility ■ Home and Community Based Alternatives (HCBA) ■ Waiver Personal Care Services (WPCS) ■ None of the Above Is the Member at risk for hospitalization, or institutionalization in a nursing facility? Yes ■ No■ **AND** Has the member been diagnosed with one or more of the following conditions? Yes ■ No■ If yes, please check: ■ Muscle wasting and atrophy ■ Muscle weakness ■ Calcification and ossification of muscle ■ Palliative Care Encounter ■ Limitation of activities due to disability ■ Bed confinement status ■ Other Reduced Mobility ■ History of Falling ■ Dependence on respirator [ventilator] status ■ Dependence on wheelchairs ■ Dependence on supplemental oxygen ■ Dependence on other enabling machines and devices ■ Need for assistance with personal care ■ Need for assistance at home and no other household member able to render care ■ Need for continuous supervision ■ Other problems related to care provider dependency ■ Problem related to care provider dependency, unspecified ■ Symptoms and signs concerning food and fluid intake ■ None of the above Has the member applied for In Home Supportive Services (IHSS)? Yes ■ No■

		***If yes, a copy of the IHSS application form is required (SOC873).** If no, is the member currently receiving In Home Support Services (IHSS)? Yes ■ No ■ ***If yes, a copy of the IHSS Functional Index and Hourly of IHSS authorized task.**

■	**Medically Tailored Meals** Provides members with Medically Tailored Meals at home after discharge from a hospital or nursing home.	Does the member have a chronic condition, such as **(select all that apply):** ■ Chronic Lung Disorders or Other Pulmonary Conditions such as Asthma/COPD, ■ Heart Failure ■ Diabetes Or Other Metabolic Conditions ■ Elevated Lead Levels ■ End-Stage Renal Disease ■ High Cholesterol ■ Human Immunodeficiency Virus ■ Hypertension ■ Liver Disease ■ Dyslipidemia ■ Fatty Liver ■ Malnutrition ■ Obesity ■ Stroke ■ Gastrointestinal Disorders ■ Gestational Diabetes ■ High Risk Perinatal Conditions ■ Chronic Or Disabling Mental/Behavioral Health Disorders ■ None of the above **AND** Are any of these chronic conditions causing nutritionally sensitive conditions? Yes ■ No ■ If yes, **select a meal preference:** ■ Packaged Meals ■ Weekly box of fruits and vegetables ■ Weekly box of products

■	**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.	Is the member currently receiving In Home Supportive Services (IHSS)? Yes ▣ No ▣ ***If yes, provide a copy of the IHSS Functional Index and Hourly of IHSS authorized task.** Is the member currently receiving Personal Care and Homemaker Services? Yes ▣ No ▣ ***If no, a KATZ assessment is required, the member will be contacted by a Kern Family Health Care representative.**

■	**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.	Does the member have a diagnosis of Persistent Asthma? Yes ▣ No ▣ **AND** If yes, has the member experienced any of the following within the past 12 months due to their Persistent Asthma diagnosis? ▣ Emergency Room Visit ▣ Hospitalization ▣ Two (2) or more urgent care visits ▣ None of the above Has the member received an In Home Trigger Assessment in the past 12 months? Yes ▣ No ▣ Is the request for: ▣ Supplies ▣ Physical Modification For <u>physical modification</u>: Does the member have legal consent from the tenant or landlord? Yes ▣ No ▣ ***If no, written consent is required.**

■	**Environmental Accessibility Adaptations (Home Modifications)** Helps modify a member's home to ensure their health, wellbeing, and safety.	Is the member receiving any of the following services: **(select all that apply):** ■ Home Access Program through the city or county ■ Multipurpose Senior Services Program (MSSP) ■ Habitat for Humanity Aging in Place/Home Repair ■ None of the above If none of the above, is the member at risk of institutionalization in a nursing facility? Yes ■ No ■ If yes, does the member's home environment present barriers to independent living or health? Yes ■ No ■ ***If yes, doctor's order, and landlord/owner consent will be required.**

Support to Recover from Acute Intoxication 		
■	**Sobering Centers** An alternate destination for individuals found to be publicly intoxicated and provide a safe, supportive environment to become sober.	Was the member transported by law enforcement, emergency personnel, County of Kern Mobile Evaluation Team (MET), Behavior Health and Recovery Services (KBHRS) or contracted provider treatment team, or other authorized community partner? **(Required)** Yes ■ No ■ Is the member at least 18 years of age? Yes ■ No ■ Are you requesting sobering centers for a member who is currently intoxicated or was intoxicated at the time of admission? Yes ■ No ■ If yes, is the member conscious, cooperative, able to walk, nonviolent, free from any medical distress? Yes ■ No ■ **Date of Service:** _____ **Sobering Center:** ■ Kern Behavioral Recovery Services ■ City Serve