# 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-Community Supports Contact Information**

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

| Support For Housing Insecurities  | | |
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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>☐ Member is experiencing homelessness or at risk of homelessness.<br>Yes □ No □<br><br>**One of the following must also be yes:**<br>☐ Member has a current eviction notice.<br>☐ Member is being asked to leave their current living situation (ie. couch surfing).<br>☐ Member resides in a hotel or motel that is paid by a charitable organization.<br><br>**Does the member suffer from any of the following**<br>☐ serious chronic condition<br>☐ mental illness<br>☐ substance abuse<br><br>**<u>AND</u>**<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><br>**Has the member received this service before?**<br>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 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><br>**Has the member received this service before?**<br>Yes □ No □ Unknown □ |
| □ | **Day Habilitation**<br>The program aims to support the Member in developing, maintaining and enhancing self-help, socialization, and adaptive abilities. | **Select all that apply:**<br>☐ Member is homeless or at risk of being homeless.<br>☐ Member has been institutionalized and his/her housing stability can be improved with program.<br>☐ Member exited homelessness<br>**AND**<br>☐ Entered housing in the last 24 months. |

| **Support for Post-Acute Care Admission or Post-Nursing Facility Admission**  | | |
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| □ | **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>**AND**<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><br>*When possible, please submit discharge summary/documents.* |

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| □ | **Recuperative Care**<br><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 one 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><br>*When possible, please submit discharge summary/documents.* |
| □ | **Nursing Facility Transition/Diversion to Assisted Living Facility**<br><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. | ☐ Nursing Facility Transition<br>**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**<br>3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports and services.<br><br>**Member meets ALL criteria in this section to qualify:** Yes □ No □<br><br>**Received this service before?** Yes □ No □ Unknown □<br><br>☐ Nursing Facility Diversion<br>**Review the following eligibility criteria:**<br>1. Member interested in remaining in the community; **and**<br>2. Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; **and**<br>3. Member is currently receiving medically necessary nursing facility LOC services or meet the minimum criteria to receive those services in an assisted living facility.<br><br>**Member meets ALL criteria in this section to qualify:** Yes □ No □ |

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| □ | **Community Transition Services/Nursing Facility Transition**<br><br>Provides nursing facility transition to a home. | **Review the following eligibility criteria:**<br><br>1. Member is 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><br>2. Member has lived 60+ days in a nursing home or medical respite setting.<br><br>**AND**<br><br>3. Member is interested in moving back to the community; and<br><br>4. Member is able to reside safely in the community with appropriate and cost- effective supports and services.<br><br>**Member meets ALL criteria in this section to qualify:** Yes □ No □ |

| **Support for Members in the Home**  | | |
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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 <u>one</u> that applies:**<br><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>Is a family member or friend interested in becoming a caregiver?<br><br>Yes □ No □ Unknown □ |

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| □ | **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 lung disorders<br>☐ Human Immunodeficiency virus<br>☐ Gestational Diabetes<br>☐ High risk perinatal conditions<br>☐ Disabling mental/behavioral health disorders<br>☐ Other: (fill in if possible)<br><br>**AND**<br><br>☐ Member is being discharged from the hospital or skilled nursing facility? Please provide:<br>Facility Name:<br>Facility Type:<br>Date of Discharge:<br><br>☐ Member at risk for institutionalization?<br>Please provide documentation.<br><br>**OR**<br><br>☐ Is the member enrolled in an ECM or Complex Case Management Program |
| □ | **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>☐ Member requires assistance with their Activities of Daily Living.<br>☐ Member is dependent on a qualified caregiver and without one, member would be at risk of institutional placement.<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 |

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| □ | **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. |
| □ | **Environmental Accessibility Adaptations (Home Modifications)**<br><br>Helps modify a member's home to ensure their health, wellbeing, and safety. | **Review the following eligibility criteria:**<br><br>1. Are the modifications necessary to ensure the health, welfare, or safety of the member?<br><br>Yes □ No □<br><br>2. Will the modifications allow the member to function with higher independency?<br><br>Yes □ No □<br><br>3. Is the member at risk for institutionalization in a nursing facility?<br><br>Yes □ No □ |

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| | **Support to Recover from Acute Intoxication**  | |
| □ | **Sobering Centers**<br><br>An alternate destination for individuals found to be publicly intoxicated and provide a safe, supportive environment to become sober. | **Review the following eligibility criteria:**<br><br>1. Is the member at least 18 years of age?<br><br>Yes □ No □<br><br>2. Are you requesting sobering centers for a member who is currently intoxicated at the time of admission?<br><br>Yes □ No □<br><br>3. Is the member intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress?<br><br>Yes □ No □ |