



# 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: <a href="mailto:cssteam@khs-net.com">cssteam@khs-net.com</a>	Kern Family Health Care 2900 Buck Owens Blvd Bakersfield, CA 93309

## Support For Housing Insecurities




<input type="checkbox"/>	<p><b>Housing Transition Navigation Services</b></p> <p>Assists members with obtaining housing and preparing for move-in.</p>	<p>Is the member experiencing homelessness or at risk of homelessness?</p> <p><b>Select <u>one</u>:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Experiencing Homelessness.</li> <li><input type="checkbox"/> At Risk of Homelessness.</li> <li><input type="checkbox"/> None of the Above.</li> </ul> <p>If <u>experiencing homelessness</u>, <b>identify the homeless category that applies:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The member lacks a fixed, regular and adequate night-time residence.</li> <li><input type="checkbox"/> The member lacks living in a place not meant for human habitation (e.g., streets, cars, encampments).</li> <li><input type="checkbox"/> 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.</li> </ul> <p>If at <u>risk of homelessness</u>, <b>select what applies:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The member will lose primary night-time residence within 14 days. (<b>eviction notice or pay or quit notice/documentation required</b>)</li> <li><input type="checkbox"/> The member is fleeing or attempting to flee a domestic violence, dating violence, sexual assault, stalking, or other dangerous/life-threatening conditions. (<b>provide police report or letter from supportive services</b>)</li> <li><input type="checkbox"/> The member is a youth under the age of 25 who has not had stable housing in the past 60 days.</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>Does the member have one of the following clinical risk factors?</p> <p><b>Select <u>all</u> that applies:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The member currently receives specialty mental health services. (e.g., Kern Behavioral Health and Recovery Services)</li> <li><input type="checkbox"/> The member has one or more serious chronic physical health conditions.</li> <li><input type="checkbox"/> The member has been diagnosed with a physical, intellectual or disabling condition.</li> <li><input type="checkbox"/> The member is pregnant or is up to 12 months postpartum.</li> <li><input type="checkbox"/> None of the Above.</li> </ul>
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<div data-bbox="99 233 120 254" data-label="Text"> <input type="checkbox"/> </div> <div data-bbox="164 262 389 296" data-label="Section-Header"> <h3>Housing Deposit</h3> </div> <div data-bbox="164 336 509 621" data-label="Text"> <p>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.</p> </div>	<div data-bbox="550 262 1451 296" data-label="Text"> <p>Is or has the member received Housing Transition/Navigation Services?</p> </div> <div data-bbox="826 336 990 365" data-label="Text"> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> </div> <div data-bbox="550 409 1539 443" data-label="Text"> <p>If yes, does the member have a housing plan? <b>(required to receive this service)</b></p> </div> <div data-bbox="826 483 990 512" data-label="Text"> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> </div> <div data-bbox="550 535 1516 569" data-label="Text"> <p>Is the member experiencing homelessness or at risk of becoming homeless?</p> </div> <div data-bbox="555 571 703 602" data-label="Text"> <p><b>Select <u>one</u>:</b></p> </div> <div data-bbox="589 609 990 714" data-label="List-Group"> <ul style="list-style-type: none"> <li><input type="checkbox"/> Experiencing homelessness</li> <li><input type="checkbox"/> At risk of homelessness</li> <li><input type="checkbox"/> None of the above</li> </ul> </div> <div data-bbox="555 758 1213 791" data-label="Text"> <p>If <u>experience homelessness</u>, <b>(select all that apply)</b>:</p> </div> <div data-bbox="589 795 1395 1123" data-label="List-Group"> <ul style="list-style-type: none"> <li><input type="checkbox"/> The member lacks a fixed, regular and adequate nighttime residence</li> <li><input type="checkbox"/> The member is living in a place not meant for human habitation (e.g., streets, cars, encampments)</li> <li><input type="checkbox"/> 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</li> <li><input type="checkbox"/> The member is currently prioritized for permanent supporting housing</li> </ul> </div> <div data-bbox="555 1178 1190 1211" data-label="Text"> <p>If <u>at risk of homelessness</u>, <b>(select all that apply)</b>:</p> </div> <div data-bbox="589 1215 1416 1537" data-label="List-Group"> <ul style="list-style-type: none"> <li><input type="checkbox"/> The member will lose primary nighttime residence within 14 days. <b>(Eviction notice or pay or quit notice/documentation required)</b></li> <li><input type="checkbox"/> The member is fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous/life-threatening conditions. <b>(Provide police report or letter from supportive services.)</b></li> <li><input type="checkbox"/> The member is a youth under the age of 25 who has not had stable housing in the past 60 days.</li> </ul> </div>
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<div data-bbox="99 226 496 493"> <input type="checkbox"/> <div> <b>Housing Tenancy and Sustaining Services</b>  Provides education, coaching and support to maintain a safe and stable tenancy once housing is secured. </div> </div>	<div data-bbox="548 226 1471 260"> Is or has the member received Housing Transition/Navigation Services? </div> <div data-bbox="837 300 990 331"> Yes <input type="checkbox"/> No <input type="checkbox"/> </div> <div data-bbox="548 352 1518 386"> Is the member experiencing homelessness or at risk of becoming homeless? </div> <div data-bbox="557 390 701 422"> <b>Select <u>one</u>:</b> </div> <div data-bbox="591 428 990 535"> <div><input type="checkbox"/> Experiencing homelessness</div> <div><input type="checkbox"/> At risk of homelessness</div> <div><input type="checkbox"/> None of the above</div> </div> <div data-bbox="557 592 1213 625"> If <u>experience homelessness</u>, (<b>select all that apply</b>): </div> <div data-bbox="591 632 1393 959"> <div><input type="checkbox"/> The member lacks a fixed, regular and adequate night-time residence.</div> <div><input type="checkbox"/> The member is living in a place not meant for human habitation (e.g., streets, cars, encampments).</div> <div><input type="checkbox"/> 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.</div> <div><input type="checkbox"/> The member is currently prioritized for permanent supporting housing.</div> </div> <div data-bbox="557 997 1188 1031"> If <u>at risk of homelessness</u>, (<b>select all that apply</b>): </div> <div data-bbox="591 1037 1414 1354"> <div><input type="checkbox"/> The member will lose primary nighttime residence within 14 days (<b>Eviction notice or pay or quit notice/documentation required</b>)</div> <div><input type="checkbox"/> The member is fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous/life-threatening conditions. (<b>Provide police report or letter from supportive services.</b>)</div> <div><input type="checkbox"/> The member is a youth under the age of 25 who has not had stable housing in the past 60 days.</div> </div> <div data-bbox="953 1394 1023 1425"> <p style="text-align: center;"><b>AND</b></p> </div> <div data-bbox="557 1465 1282 1499"> Does the member have one of the following risk factors? </div> <div data-bbox="565 1503 842 1537"> <b>Select <u>all</u> that apply:</b> </div> <div data-bbox="591 1541 1414 1862"> <div><input type="checkbox"/> The member currently receives specialty mental health services (e.g. Kern Behavioral Health and Recovery Services).</div> <div><input type="checkbox"/> The member has one or more serious chronic physical health conditions.</div> <div><input type="checkbox"/> The member has been diagnosed with a physical, intellectual or disabling condition.</div> <div><input type="checkbox"/> The member is pregnant or is up to 12 months postpartum.</div> <div><input type="checkbox"/> None of the above</div> </div>
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<input type="checkbox"/>	<p><b>Day Habilitation</b></p> <p>The program aims to support the Member in developing, maintaining and enhancing self-help, socialization, and adaptive abilities.</p>	<p>Is the member experiencing homelessness?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, select the current situation (<b>select <u>one</u></b>):</p> <p><input type="checkbox"/> The member is living in a place not meant for human habitation (e.g., streets, cars, encampments).</p> <p><input type="checkbox"/> 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.</p> <p>If no, is the member at risk of homelessness or institutionalization?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, <b>select <u>all</u> that apply</b>:</p> <p><input type="checkbox"/> The member will lose primary night-time residence within 14 days.</p> <p><input type="checkbox"/> The member will have no subsequent residence has been identified.</p> <p><input type="checkbox"/> The member lacks the resources or support networks to obtain housing.</p> <p>Has the member exited homelessness and entered housing in the last 24 months?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<b>Support for Post-Acute Care Admission or Post-Nursing Facility Admission</b> 												
<input type="checkbox"/>	<p><b>Short-Term Post-Hospitalization Housing (STPHH)</b></p> <p>Assists members with high medical or behavioral health needs with short-term housing after leaving the hospital, recovery facility, Recuperative Care or other facility.</p>	<p>Has the member been recently discharged or is being discharged from a hospital or institution?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, select the facility type and include the discharge date (<b>MM/DD/YYYY</b>).</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Recuperative Care</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Hospital</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Psychiatric facility</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Nursing facility</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Residential Treatment Center</td> <td>_____</td> </tr> </table> <p style="text-align: center;"><b>AND</b></p> <p>Is the member experiencing or at risk of homelessness?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<input type="checkbox"/> Recuperative Care	_____	<input type="checkbox"/> Hospital	_____	<input type="checkbox"/> Psychiatric facility	_____	<input type="checkbox"/> Nursing facility	_____	<input type="checkbox"/> Residential Treatment Center	_____
<input type="checkbox"/> Recuperative Care	_____											
<input type="checkbox"/> Hospital	_____											
<input type="checkbox"/> Psychiatric facility	_____											
<input type="checkbox"/> Nursing facility	_____											
<input type="checkbox"/> Residential Treatment Center	_____											

		<p>Please select <b><u>all</u></b> that apply:</p> <p><input type="checkbox"/> Is the member receiving ECM services.</p> <p><input type="checkbox"/> Is the member diagnosed with 1 or more serious chronic conditions.</p> <p><input type="checkbox"/> Is the member diagnosed with a serious mental illness.</p> <p><input type="checkbox"/> Is the member at risk of institutionalization or requiring residential services as a result of a substance use disorder.</p> <p><input type="checkbox"/> None of the above</p> <p>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?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<input type="checkbox"/>	<p><b>Recuperative Care</b></p> <p>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.</p>	<p>Has the member recently been discharged from the hospital?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, include the hospital name and discharge date:</p> <p>_____</p> <p>Hospital Name Discharge Date (MM/DD/YYYY)</p> <p>Is the member recovering from a physical illness, injury, or surgery that still requires medical oversight?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, is the member experiencing or at risk of homelessness?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<input type="checkbox"/>	<p><b>Assisted Living Facility (ALF) Transitions</b></p> <p>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.</p>	<p>Is the member residing in a Nursing Facility or Community/Home? (select one):</p> <p style="margin-left: 40px;"> <input type="checkbox"/> Nursing Facility  <input type="checkbox"/> Community or Home         </p> <p><b>If Nursing Facility is selected:</b>          Has the member resided 60+ days in a nursing facility?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><b>AND</b></p> <p>Is the member willing to live in an assisted living setting as an alternative to a nursing facility?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><b>AND</b></p> <p>Is the member able to reside safely in an assisted living facility with appropriate and cost-effective support?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>If Community or Home is selected:</b>          Is the member interested in remaining in the community?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><b>AND</b></p> <p>Is the member willing and able to reside safely in an assisted living facility?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><b>AND</b></p> <p>Does the member meet the minimum criteria to receive nursing facility Level of Care (LOC) services?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<input type="checkbox"/>	<p><b>Community or Home Transition Services</b></p> <p>Provides nursing facility transition to a home.</p>	<p>Does the member receive assistance from the California Community Transition (CCT) program?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no, does the member receive assistance from Home and Community Based Alternative (HCBA) Waiver?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no, does the member receive assistance from the Multipurpose Senior Services Program (MSSP)?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no, where is the member currently residing?</p> <p> <input type="checkbox"/> Nursing Facility  <input type="checkbox"/> Recuperative Care  <input type="checkbox"/> None of the Above         </p> <p>Is the member currently receiving medically necessary nursing facility Level of Care (LOC)?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>AND</b></p> <p>Has the member resided 60+ days in a nursing home or recuperative care setting?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>AND</b></p> <p>Is the member interested in moving back to the community?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>AND</b></p> <p>Is the member able to reside safely in the community with appropriate and cost-effective support and services?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the member able to pay for their own monthly or mortgage expenses?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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## Support for Members in the Home



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### 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 ☐


		<p><b>*If yes, a copy of the IHSS application form is required (SOC873).</b></p> <p>If no, is the member currently receiving In Home Support Services (IHSS)?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>*If yes, a copy of the IHSS Functional Index and Hourly of IHSS authorized task.</b></p>
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<input type="checkbox"/>	<p><b>Medically Tailored Meals</b></p> <p>Provides members with Medically Tailored Meals at home after discharge from a hospital or nursing home.</p>	<p>Does the member have a chronic condition, such as <b>(select all that apply):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Lung Disorders or Other Pulmonary Conditions such as Asthma/COPD,</li> <li><input type="checkbox"/> Heart Failure</li> <li><input type="checkbox"/> Diabetes Or Other Metabolic Conditions</li> <li><input type="checkbox"/> Elevated Lead Levels</li> <li><input type="checkbox"/> End-Stage Renal Disease</li> <li><input type="checkbox"/> High Cholesterol</li> <li><input type="checkbox"/> Human Immunodeficiency Virus</li> <li><input type="checkbox"/> Hypertension</li> <li><input type="checkbox"/> Liver Disease</li> <li><input type="checkbox"/> Dyslipidemia</li> <li><input type="checkbox"/> Fatty Liver</li> <li><input type="checkbox"/> Malnutrition</li> <li><input type="checkbox"/> Obesity</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Gastrointestinal Disorders</li> <li><input type="checkbox"/> Gestational Diabetes</li> <li><input type="checkbox"/> High Risk Perinatal Conditions</li> <li><input type="checkbox"/> Chronic Or Disabling Mental/Behavioral Health Disorders</li> <li><input type="checkbox"/> None of the above</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>Are any of these chronic conditions causing nutritionally sensitive conditions?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, <b>select a meal preference:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Packaged Meals</li> <li><input type="checkbox"/> Weekly box of fruits and vegetables</li> <li><input type="checkbox"/> Weekly box of products</li> </ul>
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□	<p><b>Respite Services</b></p> <p>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.</p>	<p>Is the member currently receiving In Home Supportive Services (IHSS)?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>*If yes, provide a copy of the IHSS Functional Index and Hourly of IHSS authorized task.</b></p> <p>Is the member currently receiving Personal Care and Homemaker Services?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>*If no, a KATZ assessment is required, the member will be contacted by a Kern Family Health Care representative.</b></p>
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□	<p><b>Asthma Remediation</b></p> <p>Provides information for members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and provides needed equipment.</p>	<p>Does the member have a diagnosis of Persistent Asthma?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><b>AND</b></p> <p>If yes, has the member experienced any of the following within the past 12 months due to their Persistent Asthma diagnosis?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Emergency Room Visit</li> <li><input type="checkbox"/> Hospitalization</li> <li><input type="checkbox"/> Two (2) or more urgent care visits</li> <li><input type="checkbox"/> None of the above</li> </ul> <p>Has the member received an In Home Trigger Assessment in the past 12 months?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the request for:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Supplies</li> <li><input type="checkbox"/> Physical Modification</li> </ul> <p>For <u>physical modification</u>: Does the member have legal consent from the tenant or landlord?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>*If no, written consent is required.</b></p>
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<input type="checkbox"/>	<p><b>Environmental Accessibility Adaptations (Home Modifications)</b></p> <p>Helps modify a member's home to ensure their health, wellbeing, and safety.</p>	<p>Is the member receiving any of the following services: <b>(select all that apply):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Home Access Program through the city or county</li> <li><input type="checkbox"/> Multipurpose Senior Services Program (MSSP)</li> <li><input type="checkbox"/> Habitat for Humanity Aging in Place/Home Repair</li> <li><input type="checkbox"/> None of the above</li> </ul> <p>If <u>none of the above</u>, is the member at risk of institutionalization in a nursing facility?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, does the member's home environment present barriers to independent living or health?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>*If yes, doctor's order, and landlord/owner consent will be required.</b></p>
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<b>Support to Recover from Acute Intoxication</b> 		
<input type="checkbox"/>	<p><b>Sobering Centers</b></p> <p>An alternate destination for individuals found to be publicly intoxicated and provide a safe, supportive environment to become sober.</p>	<p>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? <b>(Required)</b></p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the member at least 18 years of age?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you requesting sobering centers for a member who is currently intoxicated or was intoxicated at the time of admission?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, is the member conscious, cooperative, able to walk, nonviolent, free from any medical distress?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Date of Service:</b> _____</p> <p><b>Sobering Center:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kern Behavioral Recovery Services</li> <li><input type="checkbox"/> City Serve</li> </ul>