Community Supports (CS) Referral Form

SNF Transition or Diversion to the Community
SNF Transition to RCFE & SNF Transition to Home

Email: CS@scfhp.com
Fax: **1-408-874-1985**

Return completed referral form and all applicable documentation via SECURE email to CS@scfhp.com or fax to **1-408-874-1985**. Allow up to 5 business days for referral to be reviewed once received. Referral forms can also be completed and submitted via the SCFHP Provider Portal. Questions? Please call our Community Supports direct line at 1-408-874-1929.

- Community Supports are medically appropriate and cost-effective alternatives to services covered under Medi-Cal, such as hospital care, nursing facility care, and emergency department (ED) utilization. Community Supports are optional services for Medi-Cal managed care plans to provide and are optional for managed care members to use. These services will vary based on enrollee needs and care plan goals.
- Transition or Diversion Community Supports are available to members that meet the following criteria. Options may have different requirements. Please ensure member meets all criteria before submitting this referral form.
- Santa Clara Family Health Plan (SCFHP) may require additional documentation to ensure members meet the criteria.
- Members may receive more than one Community Supports service at a time, however they cannot exceed lifetime maximums.

Patient/Member Information	
First Name:	Last Name:
DOB:	SCFHP Member ID:
Phone:	Authorized Representative:
Today's Date:	
Name/Agency Referral Information	
Referral Source: Choose an item.	
Agency *(if applicable)*:	Agency Phone:

Which Transition or Diversion option(s) should the member receive? *Select one*
☐ Nursing Facility Transition/Diversion to RCFE ☐ Transition ☐ Diversion ☐ Nursing Facility Transition to a Home

Eligibility Survey

Initial Community Supports Criteria:	**Yes**	**No**
1. Nursing Facility Transition to RCFE		
1a. Has member resided in a skilled nursing facility for 60 days or more?	☐	☐
1b. Is member willing to live in an RCFE instead of a skilled nursing facility?	☐	☐
1c. Does member have consistent income to cover such expense? *Members are responsible for paying their own living expenses, which includes payment for room and board.*	☐	☐
2. Diversion from Nursing Facility to RCFE		
2a. Is member currently receiving medically necessary nursing facility level of care services or meet the minimum criteria for nursing facility level of care? Nursing facility level of care criteria can be found in Chapter 7.0 of the Manual of Criteria for Medi-Cal Authorization[1]	☐	☐
2b. Does member have the desire and ability to safely remain in the community with appropriate services?	☐	☐
3. Nursing Facility Transition to Home		
3a. Has member resided in a skilled nursing facility for 60 days or more?	☐	☐
3b. Is member willing to move back to the community?	☐	☐
3c. Is member able to safely reside in the community with appropriate supports?	☐	☐
3d. Is member currently receiving medically necessary nursing facility level of care services or meet the minimum criteria for nursing facility level of care? Nursing facility level of care criteria can be found in Chapter 7.0 of the Manual of Criteria for Medi-Cal Authorization[1]	☐	☐
3f. Does member have a home in the community to move back to?	☐	☐

Member Consent

Member consent must be obtained prior to providing any Community Supports service. The member has the right to retract consent at any time.

Select the form or consent received from the member

Note if written consent was obtained please provide a copy with this request

☐ Verbal consent *(member/AOR)* ☐ Written Consent *(member/AOR)* ☐ No Consent

[1] https://bit.ly/3pOAEsh

Additional Information

Individuals should not be receiving duplicative support from other State, local tax, or federally funded programs. SCFHP is the payer of last resort for Community Support services.

1. Has member been enrolled in and/or received services to assist with transition/diversion from a nursing facility from any of the following programs in the last three months?
   - ☐ California Community Transition program (CCT) – Silicon Valley Independent Living Center (SVILC)
   - ☐ Institute on Aging- Community Living Connection (CLC) program
   - ☐ Home and Community-Based Alternative Waiver – Libertine Home Health
   - ☐ Aging Adult Services – Stanford Health Care
2. Has member received any other assistance from a community based organization and/or state, county, or city agency that helps member to remain in or transition to the community in the past three months?
   ☐ Yes ☐ No
3. Is member enrolled in Enhanced Care Management (ECM) ☐ Yes ☐ No
   If answer to question above is Yes, which community based case management agency?
4. Has member been diagnosed with any of the following chronic conditions?
   ☐ Diabetes ☐ Hypertension ☐ CHF ☐ Renal Disease ☐ Cardiovascular Disease ☐ Cancer
   ☐ Stroke ☐ Human Immunodeficiency Virus (HIV) ☐ Gestational Diabetes
   ☐ High Risk Perinatal Conditions
5. Has member been referred or diagnosed with any of the following mental/behavioral health conditions?
   ☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Schizoaffective Disorder
   ☐ Substance Use Disorder ☐ Serious Mental Illness/Serious emotional disturbance

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Attestation of Completeness and Accuracy of Information Provided

By signing below, I am attesting that all information provided is complete and correct to the best of my knowledge.

Printed Name	Title
Signature	Date