Community Supports (CS) Referral Form
Respite (Caregiver) and Personal Care and Homemaker Services

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.
- Respite (Caregiver) and Personal Care and Homemaker Services Community Supports are available to members that meet eligibility criteria based on questions asked on this referral form. Each service may have different requirements so answer all appropriate questions as accurately as possible. Referring parties are asked to ensure members meet the eligibility criteria before submitting this referral form to Santa Clara Family Health Plan (SCFHP).
- SCFHP may require additional documentation to ensure members meet the eligibility criteria.
- Members may be enrolled in more than one Community Supports at a time, however, they cannot exceed lifetime maximums.
- SCFHP prefers referral forms to be completed and submitted via the SCFHP Provider Portal.

Patient/Member Information	
First Name:	Last Name:
DOB:	SCFHP ID:
Phone:	Authorized Representative:
Today's Date:	

Name/Agency Referral Information	
Referral Source:	
Agency *(if applicable)*:	Agency Phone:
Is referring agency an SCFHP ECM Provider? ☐ Yes or ☐ No	

Which Housing Service should the member receive?
Please use a separate referral form if you are requesting both of the Community Supports options listed below

☐ Respite Services (for caregiver)

☐ Personal Care and Homemaker Services

Eligibility Survey

Respite Services: *Please answer all questions to the best of your ability.*	**Yes**	**No**
Individual Adult		
1. Does the member live in the community and require assistance with Activities of Daily Living (ADLs)?	☐	☐
2. Is the member dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement?	☐	☐
Child or Youth		
3. Please select any of the following that may apply a. Member previously received Respite Services under the Pediatrics Palliative Care Waiver b. Member is enrolled in California Children's Services (CCS) c. Member is enrolled in the Genetically Handicapped Persons Program (GHPP) d. Member is a foster care program beneficiary e. Member has Complex Care needs and relieve for the primary caregiver will avoid institutional placement	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Requested Services: *Please answer all questions to the best of your ability.*	**Yes**	**No**
4. Are services needed hourly, on an episodic basis due to the caregiver/person normally providing care to the member needing relief?	☐	☐
5. Are services needed on a short-term basis due to the caregiver/person normally providing care need for relief?	☐	☐
6. When are services needed? Immediately ☐ Within the next two weeks ☐ Within the next month ☐		
7. Are services requested for the member in their own home or another location being used as a home?	☐	☐
8. Are services requested for facility respite (an approved out-of-home location)?	☐	☐
Personal Care and Homemaker Services:	**Yes**	**No**
1. Has the member been referred to IHSS? 1A. If answer to question above is YES, has the member been approved?	☐ ☐	☐ ☐
2. Has member been approved for IHSS? 2A. If answer to question above is YES, how many hours are currently approved for IHSS? # of hours: 2B. Does the member require additional personal care or homemaker services beyond the number of approved IHSS hours?	☐ ☐	☐ ☐
3. Is the member waiting to be assessed or re-assessed by IHSS? 3A. If answer to question above is YES, does the member have a caregiver?	☐ ☐	☐ ☐

4. Has the member been determined to not meet eligibility by IHSS, but has short-term needs that could result in a short-term stay in a skilled nursing facility (SNF)?	☐	☐

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

Documentation

Please provide documentation that supports information provided above.

Respite Services:

- Documentation from a healthcare provider of diagnosis and care needs
- Documentation that verifies the caregiver is in need of relief
- If requesting extension of authorization over the maximum allowable hours, documentation supporting when primary caregiver requires additional respite due to medical treatment or hospitalization

Personal Care and Homemaker Services:

- Documentation confirming the member has been referred to, enrolled in, waiting to be assessed, or did not meet eligibility for IHSS. (i.e., IHSS application forms submitted (SOC873) with medical professional signatures, copy of the IHSS award letter the member received, copy of letter member received confirming scheduled in-home assessment)
- If the member is able to provide confirmation of IHSS hours, include a breakdown of the approved IHSS hours
- Doctor's notes or other documentation confirming short-term need for Personal care and/or Homemaker Services

Additional Information:	**Yes**	**No**
1. Is the member enrolled in Enhanced Case Management (ECM)? If the answer to the question above is yes, who is their ECM provider (lead care manager, organization name)? ECM Provider:	☐	☐
2. Has member been diagnosed with any additional chronic conditions? If the answer to questions above is YES, please provide diagnosis. Diagnosis:	☐	☐
3. Has member been diagnosed with any mental/behavioral health conditions? If the answer to questions above is YES, please provide diagnosis. Diagnosis:	☐	☐

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
Email	Best Contact Number
Signature	Date