Santa Clara Family Health Plan

Community Supports (CS) Referral Form

Medically-Supportive Food

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. These services will vary based on enrollee needs and care plan goals.
- Medically-Supportive Food Community Supports are available to members that meet the following applicable criteria. Options may have different requirements. Please ensure member meets all required criteria before submitting the application.
- Santa Clara Family Health Plan may require additional documentation to ensure members meet criteria.
- Members may be enrolled in more than one Community Supports 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:	
Agency *(if applicable)*:	Agency Phone:

Which Medically—Supportive Meal option(s) should the member receive? *Please note, members may only receive one of options A-D. Option F can be paired with any of the options when medically necessary. SCFHP has the final determination for eligibility. Please select all that apply.*
☐ Service Bundle A: Hot Daily Meal Delivery
☐ Service Bundle B: Frozen or Refrigerated Weekly Meal Delivery
☐ Service Bundle C: Medically-Supportive Meals
☐ Service Bundle D: Medically-Tailored Meals (MTMs)
☐ Service Bundle E: Medically-Supportive Food and Nutrition Services
☐ Service Bundle F: Enhanced Services - Education

Eligibility Survey

Diagnoses *Please provide 1-5 diagnoses and the corresponding diadnosis codes.*

Initial Community Supports Criteria:	**Yes**	**No**
1. Is member housed in Santa Clara County?	☐	☐
2. Does member have the ability to safely store 8 to 21 meals refrigerated or frozen meals or 1 large box/3-4 bags of food twice a week at one time?	☐	☐
3. Does member have ability to reheat food? ☐ Microwave ☐ Oven	☐	☐
4. Has member been discharged or have a pending discharge from acute hospital or SNF in the last or next week (7 days)? If yes, select the type of facility: ☐ Discharge- Acute Hospital ☐ Discharge- SNF ☐ Pending Discharge- Acute Hospital ☐ Pending Discharge- SNF	☐	☐
5. If requesting Bundle B: weekly frozen or refrigerated meals, did member decline hot daily meals?	☐	☐
6. Has member been discharged or have a pending discharge from acute hospital or SNF in the last or next 2-4 weeks? If yes, select the type of facility: ☐ Discharge- Acute Hospital ☐ Discharge- SNF ☐ Pending Discharge- Acute Hospital ☐ Pending Discharge- SNF	☐	☐
7. Does member live alone?	☐	☐
8. Does member have extensive care coordination needs? *e.g. 3 or more inpatient stays within last year with a length of stay of 7 or more days and 3 or more chronic conditions; or a combination of homelessness and 1 of the previous criteria*	☐	☐
9. Does member have reliable support for ADL/IADL's in the community? Reliable support can be family member(s), caregiver through IHSS, caregiver – paid privately, spouse, or other support. If yes, What days per week does member have reliable support? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday What type of reliable support does member have? ☐ Family member(s) ☐ Caregiver through IHSS ☐ Caregiver- paid privately ☐ Spouse ☐ Other support	☐	☐
10. Is member willing to participate in weekly wellness screenings? ☐ In-person ☐ Telephonic	☐	☐
11. Has member visited their PCP in the last 6 months?	☐	☐
12. Can member or referring provider provide recent lab work that may include: A1C, nutritional panel, or other clinical?	☐	☐
13. Does member have dietary and/or preferences restrictions that may require alternatives or substitutions to meal plans? If YES, select all that apply: ☐ Gluten-free ☐ Vegetarian ☐ Low sodium ☐ Diabetes ☐ Hypertension ☐ Renal disease ☐ Cancer ☐ Congestive heart failure ☐ Pureed ☐ Other	☐	☐

14. If groceries are provided rather than meals, will the member or caregiver be able to cook the full meals?	☐	☐
15. If requesting Service Bundle F ONLY, please provide authorization number to approved Meals Community Support.		

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

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 Supports services.
1. Has member been enrolled in and/or received home meal delivery services from any of the following programs in the last three months? ☐ Sourcewise- Great Plates Delivery (GDP) ☐ Sourcewise- Meals on Wheels ☐ The Health Trust- Meals on Wheels ☐ Santa Clara County Senior Nutrition Program
2. Has member received any other meal assistance from a community based organization and/or state, county, or city agency in the past three months? ☐ Yes ☐ No
3. Is member enrolled in SCFHP Enhanced Care Management (ECM)? ☐ Yes ☐ No If YES, with what provider?

<u>**Attestation of Completeness and Accuracy of Information Provided**</u>	
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