

## COMMUNITY SUPPORTS (CS) REFERRAL FORM

MEMBER INFORMATION		
<i>Please print or type</i>		
Last Name: _____	First Name: _____	Date: _____
Mailing Address: _____	City: _____	Zip: _____
Medi-Cal ID: _____	Phone: _____	Birth Date: _____
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		

REFERRAL SOURCE INFORMATION		
Last Name: _____	First Name: _____	
Mailing Address: _____	City: _____	Zip: _____
Phone: _____	Email: _____	
<b>RELATION TO MEMBER:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Family / Friend <input type="checkbox"/> Primary Care Provider (PCP) <input type="checkbox"/> Enhanced Care Management (ECM) Provider <input type="checkbox"/> Other Service Provider <input type="checkbox"/> GCHP Staff <input type="checkbox"/> Community Based Organization (CBO)		
<b>PREFERRED CONTACT METHOD:</b> <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Mail		
<b>REFERRING ORGANIZATION</b> (if applicable): _____		
<b>HAS THE MEMBER BEEN INFORMED THAT A REFERRAL WAS BEING SUBMITTED?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

REASON FOR REFERRAL <i>(check all that apply)</i>		
Community Support	What is it?	Who is eligible?
<input type="checkbox"/> Medically Supportive Food	Meals designed for specific medical needs following hospitalization.	Members who had a hospital stay for diabetes- or Congestive Heart Failure-related reasons within the past 30 days.
<input type="checkbox"/> Housing Transition Navigation	Help with finding and getting housing, including help with housing applications.	Members who are homeless or at risk of homelessness and at least one of the following: <ul style="list-style-type: none"> <li>Have one or more serious chronic conditions</li> <li>Serious mental illness / substance use disorder</li> <li>At risk of institutionalization</li> <li>Serious emotional disturbance (children / adolescents)</li> <li>Exiting incarceration OR</li> <li>Transitional-aged youth with significant barriers to housing</li> </ul>
<input type="checkbox"/> Housing Deposits  <small>* Must be receiving Housing Transition Navigation Services.</small>	Funding for one-time services necessary to establish a household, including security deposits, first month's utilities, equipment needed for a health condition, or first and last month's rent.	
<input type="checkbox"/> Housing Tenancy and Sustaining Services	Help with keeping housing, including help with managing money and good tenant behaviors.	
<input type="checkbox"/> Recuperative Care	Short-term housing and medical care for members leaving the hospital who are likely to get worse without support.	Members who are at risk of being admitted or re-admitted into the hospital AND at least one of the following: <ul style="list-style-type: none"> <li>Are homeless or at risk of homelessness.</li> <li>Live alone with no formal supports.</li> <li>Housing insecurity that puts their health and safety at risk.</li> </ul>



REASON FOR REFERRAL <i>(check all that apply)</i>		
Community Support	What is it?	Who is eligible?
<input type="checkbox"/> Short-Term Post-Hospitalization Housing	Short-term housing and medical support for members leaving a hospital or treatment facility. This is a one-time service.	<ul style="list-style-type: none"> <li>Individuals who are homeless.</li> <li>Individuals that are exiting recuperative care.</li> <li>Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who are receiving enhanced care management (ECM) or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder.</li> </ul>
<input type="checkbox"/> Respite Care	Respite Services are provided to caregivers of members who require intermittent, temporary supervision. The services are offered short term because of the need for relief of the caregiver. This service is distinct from medical respite / recuperative care and is rest for the caregiver only.	Members who live in the community and are dependent upon a qualified caregiver to provide most of their support, including Activities of Daily Living (ADLs), and who require caregiver relief to avoid institutional placement.
<input type="checkbox"/> Personal Homemaker Services	Provides for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs), such as meal preparation, grocery shopping, and money management.	<ul style="list-style-type: none"> <li>Individuals at risk for hospitalization or institutionalization in a nursing facility; OR</li> <li>Individuals with functional deficits and no other adequate support system; OR</li> <li>For Individuals approved for In-Home Supportive Services (IHSS), this cannot be used instead of, but may be used in addition to, IHSS. Members must be referred to the IHSS program when they meet referral criteria.</li> </ul>
<input type="checkbox"/> Nursing Facility Transition / Diversion to Assisted Living Facilities	Nursing Facility Transition / Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.	<p>For Nursing Facility Transition:</p> <ul style="list-style-type: none"> <li>Has resided 60+ days in a nursing facility; AND</li> <li>Willing to live in an assisted living setting instead of a Nursing Facility; AND</li> <li>Able to reside safely in an assisted living facility with appropriate and cost-effective support.</li> </ul> <p>For Nursing Facility Diversion:</p> <ul style="list-style-type: none"> <li>Currently receiving medically necessary nursing facility Level of Care (LOC); AND</li> <li>Willing and able to live safely in an assisted living facility with appropriate and cost-effective support and services; AND</li> <li>Must be receiving medically necessary nursing facility care or meet the minimum criteria to receive nursing facility services. Instead of going into a facility, members choose to remain in the community. They could receive needed services at an Assisted Living Facility.</li> </ul>



REASON FOR REFERRAL <i>(check all that apply)</i>		
Community Support	What is it?	Who is eligible?
<input type="checkbox"/> Community Transition Services / Nursing Facility Transition to a Home	<p>Helps individuals to live in the community and avoid further institutionalization.</p>	<ul style="list-style-type: none"> <li>• Member is currently receiving medically necessary nursing facility Level of Care (LOC) services and, instead 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</li> <li>• Has lived 60+ days in a nursing home and/or Medical Respite setting; AND</li> <li>• Interested in moving back to the community; AND</li> <li>• Able to reside safely in the community with appropriate and cost-effective support and services.</li> </ul>
<input type="checkbox"/> Environmental Accessibility Adaptations (EAAs also, known as Home Modifications)	<p>These are physical adaptations necessary to ensure the individual's health, welfare, and safety or enable the individual to function with greater independence in the home, without which the member would require institutionalization.</p> <p>Examples of environmental accessibility adaptations include:</p> <ul style="list-style-type: none"> <li>• Ramps and grab-bars to assist members in accessing the home;</li> <li>• Doorway widening for members who require a wheelchair;</li> <li>• Stairlifts;</li> <li>• Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);</li> <li>• Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the member; AND</li> <li>• Installation and testing of a Personal Emergency Response System (PERS) for members who are alone for significant time and require routine supervision (including monthly service costs).</li> </ul>	<p>Individuals at risk for institutionalization in a nursing facility.</p> <p>Restrictions / Limitations:</p> <ul style="list-style-type: none"> <li>• Physical therapy and occupational assessments will be needed to determine the member's needs.</li> <li>• If another State Plan service, such as Durable Medical Equipment, would accomplish the same independence goals and avoid institutional placement, that service should be used.</li> <li>• EAAs must be conducted following applicable state and local building codes.</li> <li>• EAAs are payable up to a total lifetime maximum of \$7,500. The only exceptions to the \$7,500 maximum are:             <ul style="list-style-type: none"> <li>» If the member's place of residence changes, OR</li> <li>» If the member's condition has changed so significantly those additional modifications are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization</li> </ul> </li> </ul>