



CalAIM Community Supports Referral Form

Member Name: _____ **CIN:** _____

Note: Member must be eligible with CalOptima Health.

Step 1: Please fill out all applicable information below and proceed to Steps 2 and 3. Fields with an asterisk* are required.

Referral Information:

Referral Date*: _____ Referred by*: _____

Agency or Relationship to Member*: _____

Referring Provider National Provider Identifier (NPI) (if applicable): _____

Phone*: _____ Fax: _____ Email*: _____

Member Information:

Member Name*: _____ CIN*: _____

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 the Community Supports the member is interested in receiving. The following pages provide additional eligibility information about Community Supports. **Please complete all required checkboxes prior to submission.**

Step 3: Fax or mail the completed referral form and supporting documents to CalOptima Health.

CalOptima Health Community Supports Health Network Contact Information

Health Network	Customer Service Phone Number (for Members)	Referral Submission	Mailing Address
CalOptima Health Direct and Health Networks	1-888-587-8088	Fax: 1-714-338-3145	CalOptima Health Attn: LTSS CalAIM P.O. Box 11033 Orange, CA 92856

Housing Services

<input type="checkbox"/>	<p>Housing Transition Navigation Services</p> <p>Assists members with obtaining housing and preparing for move-in.</p>	<p>Select <u>1</u> that applies:</p> <p><input type="checkbox"/> Member is homeless</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> Member is at risk of homelessness with significant barriers to housing</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System</p>
<input type="checkbox"/>	<p>Housing Deposit</p> <p>Identifies, coordinates and funds move-in costs and services for a basic household, excluding room and board. Members must be receiving Housing Transition Navigation Services.</p>	<p>Select all that apply:</p> <p><input type="checkbox"/> Member is homeless or at risk of homelessness</p> <p><input type="checkbox"/> Member is receiving Housing Transition Navigation Services</p> <p style="padding-left: 40px;">Enter name of housing navigation provider: _____</p> <p style="padding-left: 40px;"><i>(Additional documentation will be requested from this provider.)</i></p> <p><input type="checkbox"/> Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System</p> <p>Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>
<input type="checkbox"/>	<p>Housing Tenancy and Sustaining Services</p> <p>Provides education, coaching and support to maintain a safe and stable tenancy once housing is secured.</p>	<p>Select all that apply:</p> <p><input type="checkbox"/> Member is homeless</p> <p><input type="checkbox"/> Member has received Housing Transition Navigation Services</p> <p style="padding-left: 40px;">Enter name of housing navigation provider: _____</p> <p style="padding-left: 40px;"><i>(Additional documentation will be requested from this provider.)</i></p> <p><input type="checkbox"/> Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System</p> <p>Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>
<input type="checkbox"/>	<p>Day Habilitation</p> <p>Assists members with self-help skills, socialization and adaptive skills needed to remain in their natural setting.</p>	<p>Select <u>1</u> that applies:</p> <p><input type="checkbox"/> Member is homeless</p> <p><input type="checkbox"/> Member is at risk of homelessness or institutionalization</p> <p><input type="checkbox"/> Member left homelessness and entered housing in the past 24 months</p>

Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission

<input type="checkbox"/>	<p>Recuperative Care 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>Select <u>1</u> that applies:</p> <p><input type="checkbox"/> Member is homeless or at risk of homelessness</p> <p><input type="checkbox"/> Member is at risk of hospitalization or is post-hospitalization</p> <p><input type="checkbox"/> Member lives alone with no formal supports</p> <p><i>Please attach the Recuperative Care or STPHH Referral Form</i></p>
<input type="checkbox"/>	<p>Short-Term Post-Hospitalization Housing (STPHH) Assists members who have high medical or behavioral health needs with short-term housing after leaving the hospital, recovery facility, recuperative care or other facility.</p>	<p>Select all that apply:</p> <p><input type="checkbox"/> Member is homeless or at risk of homelessness</p> <p align="center"><u>AND</u></p> <p><input type="checkbox"/> Member is exiting recuperative care, inpatient hospital, residential substance use disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility</p> <p><i>Please attach the Recuperative Care or STPHH Referral Form</i></p>
<input type="checkbox"/>	<p>Community Transition Service Provides nursing facility transition to a home.</p>	<p>Review the following eligibility criteria:</p> <ol style="list-style-type: none"> 1. Currently receiving medically necessary nursing facility level of care (LOC) services and, in lieu 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 2. Has lived 60+ days in a nursing home or medical respite setting; and 3. Interested in moving back to the community; and 4. Able to reside safely in the community with appropriate and cost-effective supports and services <p>Member meets ALL criteria in this section to qualify: Yes <input type="checkbox"/> No <input type="checkbox"/> Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>
<input type="checkbox"/>	<p>A. Nursing Facility <u>Transition</u> to Assisted Living Facility Transitions members from a nursing facility into a Residential Care Facility for Elderly or Adult Residential Facility.</p>	<p>Review the following eligibility criteria:</p> <ol style="list-style-type: none"> 1. Has resided 60+ days in a nursing facility; and 2. Willing to live in an assisted living setting as an alternative to a nursing facility; and 3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports and services <p>Member meets ALL criteria in this section to qualify: Yes <input type="checkbox"/> No <input type="checkbox"/> Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>

Services Provided in the Home

<input type="checkbox"/>	<p>B. Nursing Facility Diversion to Assisted Living Facility</p> <p>Transitions members who, without this support, would need to reside in a nursing facility and instead transitions them into a Residential Care Facility for Elderly or Adult Residential Facility.</p>	<p>Review the following eligibility criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Interested in remaining in the community; and <input type="checkbox"/> Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and <input type="checkbox"/> Must be currently receiving medically necessary nursing facility LOC services or meet the minimum criteria to receive those services in an assisted living facility <p>Member meets ALL criteria in this section to qualify: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>
<input type="checkbox"/>	<p>Personal Care and Homemaker Services</p> <p>Provides members who need help with activities of daily living (ADLs) with personal care and homemaker services.</p>	<p>Select all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Member is at risk for hospitalization or institutionalization in a nursing facility <input type="checkbox"/> Member has functional deficits and no adequate support system <p align="center"><u>AND</u></p> <p>Select 1 that applies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Member is approved for In-Home Supportive Services (IHSS) and has made a request for an increase in hours that is still pending <input type="checkbox"/> Member has applied for IHSS and is waiting to have the assessment completed <p>Has a family member or friend interested in becoming a caregiver?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>
<input type="checkbox"/>	<p>Respite Services</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>Limit is 336 hours per year.</p>	<p>Answer all sections below:</p> <p>In-Home Respite Services are provided to the member in their own home or another location being used as the home.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dependent on a qualified caregiver and without one, member would need to be in a nursing facility <p>Member has specific dates and times for needing a respite caregiver:</p> <p>Dates: _____</p> <p>Times: _____</p> <p>Member has other services that provide a caregiver:</p> <ul style="list-style-type: none"> <input type="checkbox"/> In-Home Supportive Services (IHSS) <input type="checkbox"/> Community-Based Adult Services (CBAS) <input type="checkbox"/> Regional Center <input type="checkbox"/> Private caregiver <input type="checkbox"/> Not applicable <p>Does the member need immediate caregiver services? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Services Provided in the Home

Medically Tailored Meals and/or Medical Nutrition Therapy

Provides members with Medically Tailored Meals at home after discharge from a hospital, nursing home, or as medically necessary.

Select all that apply:

Member is currently in the hospital or nursing facility and Medically Tailored Meals are a part of the discharge plan. *(This will trigger an expedited request.)*

Member must meet 1 of the following medical conditions:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiovascular disorders <input type="checkbox"/> Congestive heart failure (CHF) <input type="checkbox"/> Chronic or disabling mental/behavioral health disorders <input type="checkbox"/> Chronic kidney disease (CKD) <input type="checkbox"/> Chronic lung disorders <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Pre-diabetes, diabetes, or gestational diabetes <input type="checkbox"/> Difficulty with chewing food (e.g., wired jaw) | <ul style="list-style-type: none"> <input type="checkbox"/> Documented serious food allergy (e.g., celiac disease, peanut, etc.) <input type="checkbox"/> End-stage liver disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> High-risk perinatal conditions <input type="checkbox"/> Hypertension <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Major neurocognitive disorder <input type="checkbox"/> Obesity <input type="checkbox"/> Purine arthritis (gout) <input type="checkbox"/> Stroke <input type="checkbox"/> Other (please explain):
_____ |
|--|--|

OR

Member must meet 1 of the following utilization criteria:

- Member was recently discharged from the hospital or skilled nursing facility
- Member is at high risk of hospitalization or nursing facility placement
- Member has extensive care coordination needs

If yes, describe:

Member on a special diet? Yes No

If yes, describe:

Member is receiving other meal delivery services from local, state or federally funded programs

Has a refrigerator? Yes No

Has a way to safely reheat meals? Yes No

Services Provided in the Home

<input type="checkbox"/>	<p>Environmental Accessibility Adaptations</p> <p>Provides physical adaptations to a home that are necessary to ensure the health, welfare and safety of members, or that enable members to remain in their home.</p>	<p>Request for a Personal Emergency Response System (PERS)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Select all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Member at risk for institutionalization in a nursing facility <p align="center"><u>AND</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Member has discussed needing a home modification with primary care provider (PCP) <input type="checkbox"/> PCP has documented medical need for this service and will provide documentation upon request <p>Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>
<input type="checkbox"/>	<p>Asthma Remediation</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>Select all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Member had emergency department visit or hospitalization in the past 12 months <input type="checkbox"/> Member had 2 sick or urgent care visits in the past 12 months <input type="checkbox"/> Member has a score of 19 or lower on the Asthma Control Test <p align="center"><u>AND</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> PCP has documented medical need for this service and will provide documentation upon request <p>Received this service before? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>