

Instructions:

Please complete this form and attach the following documents: Plan of Care, Discharge Plan, PT/OT notes and H&P. Authorization may be denied if this information is not provided.

Step 1: Complete all information below.

| 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: | CalOptima Health ID: |
| Date of birth: | Member's preferred language: |
| Phone: | Email: |
| Is the member currently in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Last visit to PCP: | Next PCP visit: |

| Primary Care Provider (PCP) Information | |
|---|----------|
| Name: | Address: |
| Phone: | Email: |

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.

Step 3: Please check off the most appropriate Recuperative Care/Short-Term Post-Hospitalization Housing pathways based on the eligibility listed in the following pages.

Please note that members may not receive more than a combined 182 days of Short-Term Post-Hospitalization, Recuperative Care and Transitional Rent during any rolling 12-month period.

| | Pathway | Description | Eligibility |
|--------------------------|--|--|--|
| <input type="checkbox"/> | Recuperative Care only | Short-term residential care for individuals who no longer require hospitalization but will need to heal from an injury, illness or mental health condition. | Both must apply: <input type="checkbox"/> Homeless or at risk of homelessness <input type="checkbox"/> Member requires recovery in order to heal from an injury or illness. |
| <input type="checkbox"/> | Short-Term Post-Hospitalization Housing only | Assists members with high medical or behavioral health needs with short-term housing after leaving the hospital, recovery facility, recuperative care or other facility. | Member must meet the following criteria: (1) Member is exiting an institution, which includes recuperative care facilities, inpatient hospitals, residential substance use disorder or mental health treatment facilities, correctional facilities or nursing facilities. AND (2) Member is experiencing homelessness. AND (3) Member meets one the following criteria: a. Is receiving ECM b. Have one or more serious chronic conditions c. Have a serious mental illness; or d. Is at risk of institutionalization or requiring residential services as a result of a substance use disorder. AND (4) Member is having ongoing physical and behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing. |
| <input type="checkbox"/> | Nursing Facility with plans to transition to Recuperative Care | Short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness or a mental health condition. | Select one that applies: <input type="checkbox"/> Homeless or at risk of homelessness <input type="checkbox"/> Member who is at risk of hospitalization or at post-hospitalization <input type="checkbox"/> Members who live alone with no formal supports. |

| | | | |
|--------------------------|---|--|---|
| <input type="checkbox"/> | Recuperative Care with plans to transition to Short-Term Post-Hospitalization Housing | Short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury, illness or mental health condition. | Select one that applies: <input type="checkbox"/> Homeless or at risk of homelessness <input type="checkbox"/> Individuals who are at risk of hospitalization or at post-hospitalization <p style="text-align: center;">OR</p> <input type="checkbox"/> Individuals who live alone with no formal supports <p style="text-align: center;">AND</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. |
|--------------------------|---|--|---|

| Admitting Diagnosis | |
|---|--------------------------|
| Qualifying Recuperative Care/Short-Term Post-Hospitalization Housing diagnosis: | |
| | |
| ED visit/hospital admit date: | Expected discharge date: |

| Will the member need any specialist follow-up care? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
|---|--|
| 1) Specialty: | |
| Provider name: | |
| Phone: | |
| Scheduled appt date: | |
| 2) Specialty: | |
| Provider name: | |
| Phone: | |
| Scheduled appt date: | |
| 3) Specialty: | |
| Provider name: | |
| Phone: | |
| Scheduled appt date: | |

| Authorized Home Health Provider |
|---|
| Service(s): <input type="checkbox"/> Physical therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Speech <input type="checkbox"/> Wound care |

| | | |
|--|--------|----------------------|
| <input type="checkbox"/> Personal care | | |
| Provider name: | Phone: | Scheduled appt date: |

Health Information

General

| | |
|--|---|
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Placement needs related to gender. | COVID vaccine Dose 1: <input type="checkbox"/> Yes <input type="checkbox"/> No Dose 2: <input type="checkbox"/> Yes <input type="checkbox"/> No Booster 1: <input type="checkbox"/> Yes <input type="checkbox"/> No Booster 2: <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|

TB test or chest X-ray performed? Yes No
 If Yes, date:
 Results: Positive Negative
 Comments:

Neuro

Alert and oriented to: Person Place Time Situation

Respiratory

Requires O2 (Explain):

GI/GU

| | |
|---|---|
| <input type="checkbox"/> Incontinent of bowel <input type="checkbox"/> Incontinent of bladder <input type="checkbox"/> Colostomy/ileostomy <input type="checkbox"/> Foley catheter | Does the member require tube feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

Ambulation/Mobility

Can the member independently perform ADLs? Yes No
 How far can the member ambulate?

Does the member use DME? Yes No
 If yes, please explain:

Fractures: Yes No

Recent surgery: Yes No

Integumentary

Wound(s): Yes No
 If yes, provide location(s)/size/stage:

Independent with wound care? Yes No

Health Information

Infections

Communicable disease/isolation describe:

IV Antibiotics: Yes No

If yes, frequency:

Psycho-social Information:

Registered sex offender

Member has:

Car Spouse/partner

Service animal Pets

Substance Use None

| Type | Last Date Used |
|--|----------------|
| <input type="checkbox"/> Alcohol | |
| <input type="checkbox"/> Cocaine | |
| <input type="checkbox"/> Heroin | |
| <input type="checkbox"/> Methamphetamine | |
| <input type="checkbox"/> Opioid | |
| <input type="checkbox"/> Other | |

Mental Health DX

Anxiety Bipolar Cognitive impairment Depression Schizophrenia

Trauma-related Other (please explain):

Current treatment:

Requires assistance with ADLs, please explain:

Medication Management

Diabetic Insulin Oral meds Anticoagulants Requires INR/PT/PTT checks

Requires assistance with medication. List medication(s):

Does the member have enough medication to last through the end of the month? Yes No

| |
|--|
| Health Information |
| Does the member understand how to obtain refills on their medications? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the member have a preferred pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: |
| Does the member understand how to take their medication and why they are taking their medication? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Step 4: Based on the services selected for the member above, please submit this Referral Form to the most appropriate provider listed below via fax or mail.

Community Supports Provider Contact Information

| | |
|---|--|
| Short-Term Hospitalization | |
| Housing for Health Orange County (HHOC) | Phone: 949-208-3907 Fax number: 888-624-6775 Email: buckley.f@housingforhealthca.org |
| Short-Term Hospitalization and Recuperative Care | |
| Mom’s Retreat | Phone number: 714-904-1668 Fax number: 888-459-2407 Email: casemanager@momsretreatrecup.org |
| Illumination Foundation (serving adults and children) | Phone number: 949-273-0555 Fax number: 888-517-7123 Email: recup@ifhomeless.org |
| Select from the below only after checking the capacity for OC Providers first. | |
| Horizon Recuperative Care – San Gabriel Valley | Phone number: 626-565-1000 ext. 100 Fax number: 626-469-3702 Email: admissions@HorizonSGV.org |
| Horizon Recuperative Care – Los Angeles | Phone number: 323-676-1000 ext. 123 Fax number: 323-676-2000 Email: admissions@horizoncenters.org |
| Harbor Care Center – Mission Hills | Phone number: 818-925-1451 Fax number: 818-350-4105 Email: info@harborcares.org |
| Harbor Care Center – Lancaster | Phone number: 818-925-1451 Fax number: 818-350-4105 Email: info@harborcares.org |



Community Supports Provider to Complete Section Below

Step 5: Complete the section below and return the response to the referrer at the hospital or skilled nursing facility. If the member belongs to Kaiser Permanente, please submit these documents directly to Kaiser Permanente.

Accepting/Not Accepting

Was the member accepted? Yes No

If the member declined service, please provide the reason: