CalAIM Recuperative Care/Short-Term Post Hospitalization Referral/Authorization Request

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? ☐ Yes ☐ 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
☐	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: ☐ Homeless or at risk of homelessness ☐ Member requires recovery in order to heal from an injury or illness.
☐	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.
☐	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: ☐ Homeless or at risk of homelessness ☐ Member who is at risk of hospitalization or at post-hospitalization ☐ Members who live alone with no formal supports.

☐	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: ☐ Homeless or at risk of homelessness ☐ Individuals who are at risk of hospitalization or at post-hospitalization **OR** ☐ Individuals who live alone with no formal supports **AND** ☐ 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? ☐ Yes ☐ 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): ☐ Physical therapy ☐ Occupational therapy ☐ Speech ☐ Wound care

☐ Personal care		
Provider name:	Phone:	Scheduled appt date:

Health Information	
General	
Gender: ☐ Male ☐ Female ☐ Placement needs related to gender.	COVID vaccine Dose 1: ☐ Yes ☐ No Dose 2: ☐ Yes ☐ No Booster 1: ☐ Yes ☐ No Booster 2: ☐ Yes ☐ 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	
☐ Incontinent of bowel ☐ Incontinent of bladder ☐ Colostomy/ileostomy ☐ Foley catheter	Does the member require tube feeding? ☐ Yes ☐ 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
☐ Alcohol	
☐ Cocaine	
☐ Heroin	
☐ Methamphetamine	
☐ Opioid	
☐ 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? ☐ Yes ☐ No
Does the member have a preferred pharmacy? ☐ Yes ☐ No If yes, where:
Does the member understand how to take their medication and why they are taking their medication? ☐ Yes ☐ 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.	
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


STOP

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: