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

Member Name: _____ **CIN:** _____

Step 1: Complete all information below.

Referral Information:

Referral Date: _____ Referred by: _____

Agency or Relationship to Member: _____ Referring Provider NPI (if applicable): _____

Phone: _____ Fax: _____ Email: _____

Member Information:

Member Name:_____ CIN:_____

Member Date of Birth: _____ Primary Care Provider:_____

Phone: _____ Email: _____

Fax:_____ Social Worker/Case Manager/RN _____

Member's Preferred Language: _____ _____

Is Member Currently in Hospital? ☐ Yes ☐ No Social Security (last 4 digits): _____

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 pathway based on the eligibility listed below.

☐	**Recuperative Care Only** **(Up to 90 days)**	Short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness or mental health condition.	**Select one that applies:** ☐ Homeless or at risk of homelessness ☐ Individuals who are at risk of hospitalization or are post-hospitalization, ☐ Individuals who live alone with no formal supports.

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☐	**Short-Term Post Hospitalization Housing Only** **(Up to 6 months)** ***Once in a lifetime benefit**	Assist member with high medical or behavioral health needs with short-term housing after leaving the hospital, recovery facility, recuperative care or other facility.	**Select all that apply:** ☐ Homeless or at risk of homelessness **AND** ☐ Member is exiting Recuperative Care, inpatient hospital, residential substance use disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility.
☐	**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 mental health condition.	**Select one that applies:** ☐ Homeless or at risk of homelessness ☐ Individuals who are at risk of hospitalization or are post-hospitalization, **OR** ☐ Individuals 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 or illness on mental health condition **Transition to:** Assist member with high medical or behavioral health needs with short-term housing after leaving the hospital, recovery facility, recuperative care or other facility.	**Select all that apply:** ☐ Homeless or at risk of homelessness ☐ Individuals who are at risk of hospitalization or are post-hospitalization, **OR** ☐ Individuals who live alone with no formal support. **AND** ☐ Member is exiting Recuperative Care, inpatient hospital, residential substance use disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility.

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Admitting Diagnosis

Qualifying Recuperative Care/ Short-Term Post Hospitalization Housing diagnosis:

_____

_____

ED Visit / Hospital Admit Date:_____Expected Discharge Date: _____

Post-Acute Discharge Instructions

Clients last visit with their PCP:_____ Their Next visit:_____

Are there any specialists that member will need to follow up with?

Specialty:_____ Provider Name:_____

Phone Number: _____ Scheduled Appt Date:_____

Specialty:_____ Provider Name:_____

Phone Number: _____ Scheduled Appt Date:_____

Specialty:_____ Provider Name:_____

Phone Number: _____ Scheduled Appt Date:_____

Authorized Home Health Provider

Service: ☐ PT ☐ OT ☐ Speech ☐ Wound Care_Provider Name:_____

Phone Number: _____ 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 Date:_____ Results: ☐ Positive ☐Negative

Neuro:

Alert and Oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation

Respiratory:

☐ Requires O2 (Explain):_____

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Member Name: _____ **CIN:** _____

GI/ GU:

☐ Incontinent of bowel ☐ Incontinent of bladder ☐ Colostomy/Ileostomy ☐ Foley Catheter

Does the client require tube feeding? ☐ YES ☐ NO

Ambulation/ Mobility:

Can the client independently perform ADLs? ☐ YES ☐ NO

Does the Client use DME? ☐ YES ☐ NO

(Explain)_____

Fractures ☐ YES ☐ NO Recent Surgery ☐ YES ☐ NO

Integumentary:

Wound(s) ☐ YES ☐ NO

Location(s)/Size/Stage:_____

Independent with wound care ☐ YES ☐ NO

Infections:

Communicable Diseases/Isolation describe: _____

IV Antibiotics: ☐ YES ☐ NO Frequency: _____

Psycho-Social Information:

☐ Registered Sex Offender

Client has a: ☐ Car ☐ Spouse/Partner ☐ Service Animal ☐ Pets

Substance Use: ☐ None ☐ Alcohol ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Opioid

Other: _____Last Date Used:

Mental Health DX: _____

☐ Anxiety ☐ Bipolar ☐ Cognitive Impairment ☐ Depression ☐ Schizophrenia ☐ Trauma-related

☐ Other *Please explain_____ ☐ Current treatment: _____

Requires assistance with ADL's (Explain):_____

Chronic Disease Management:

☐ Diabetic ☐ Insulin ☐ Oral Meds ☐ Anticoagulants ☐Requires INR/PT/PTT checks

☐ Requires Assistance with Medication

List medication(s) :_____

Does member have enough medication to last through the end of the month? ☐ YES ☐ NO

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

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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

Name	Phone Number	Fax Number	E-Mail Address
Recuperative Care			
Blue Sky Manor, Inc.	(714) 844-2667	(714) 844- 2668	referral@blueskymanorcare.com
Harbor Care Center	(818) 925-1451	(818) 350-4105	info@harborcares.org
Horizon Recuperative Care	(323) 676-1000 x1	(323) 676-2000	admissions@horizoncenters.org
Recuperative Care and Short-Term Post Hospitalization Housing			
Mom's Retreat	(714) 904-1668	(888) 459 - 2407	casemanager@momsretreatrecup.org
Illumination Foundation	(949) 273 – 0555	(888) 517 - 7123	RECUP@ifhomeless.org

----------STOP----------

Community Support Provider to complete this section

Step 5: Complete section below and return the response to the referrer at the Hospital/ Skilled Nursing Facility. If member belongs to Kaiser Permanente- please submit these documents directly to Kaiser Permanente.

Accepting/ Not Accepting:

Was the member accepted? ☐ YES ☐ NO

If member Declined- What is reason member was declined?

_____

_____