# IHSS COMMUNICATION FORM

**ihss@caloptima.org, Phone: (714) 246-8510, Fax: (714) 481-6382**

☐ **Expedited** (1-day turnaround to SSA from CalOptima) ☐ **Routine** (3-day turnaround to SSA from CalOptima)

## MEMBER INFO

DATE:

Gender:

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ ☐ M ☐ F
LAST FIRST

MEDI-CAL NUMBER (CIN): _____ CMIPS ID: _____

LANGUAGE/ALT FORMAT: _____ IHSS PROVIDER NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: (_____) _____

ALTERNATE CONTACT: _____ PHONE: (_____) _____

PRIMARY HEALTH CARE PROVIDER: _____ PHONE: (_____) _____

DOCUMENTS INCLUDED WITH REFERRAL: _____ DIAGNOSIS: _____

HEALTH NETWORK: _____PCC NAME: _____

COMMENTS: _____

_____

_____

_____

## REASON FOR COMMUNICATION TO SSA

☐

☐ Interdisciplinary Care Team (ICT): ICT date: _____/_____/_____

☐ Notification of inpatient hospitalization; Admission date: _____

☐ Notification of skilled nursing facility admission; Admission date: _____/_____/_____ Facility: _____

☐ Notification of long-term care facility placement; Placement date: _____/_____/_____ Facility: _____

☐ Request re-evaluation/assessment of IHSS hours due to: _____

☐ Change in member's medical or functional status: _____

☐ Recent hospitalization; Discharge date: _____/_____/_____ Reason for hospitalization: _____

☐ Change in IHSS caregiver availability comments: _____

☐ Member enrolled in ☐ CBAS ☐ PACE ☐ MSSP ☐ CM Effective Date: _____/_____/_____ End Date: _____/_____/_____

☐ Change in member's eligibility status: ☐ Expired ☐ Disenrolled

***Pertinent Current Information:***

Current conditions: _____

ADL/IADL limitations: _____

Comments: _____

_____

_____

_____

# IHSS COMMUNICATION FORM

**ihss@caloptima.org, Phone: (714) 246-8510, Fax: (714) 481-6382**

## IHSS COMMUNICATION TO CALOPTIMA

DATE:

IHSS Social Worker Name: _____Phone: (_____) _____

IHSS Social Worker Email: _____

☐ Change in member's functional status: _____

☐ Member may need case management: _____

☐ Member may need durable medical equipment: _____

☐ Member may need an interdisciplinary team conference: _____

☐ Last home visit date: _____ /_____/_____

☐ Declined services date: _____/_____/_____ Reason: _____

_____

_____

_____

☐ Need health care certificate

☐ Need physician's certification for medical necessity

**IHSS: Please Notify CalOptima Case Manager of Outcome IHSS@Caloptima.org, Fax: 714 481-6382**