



Community Supports – Member Referral Form

Community Supports (CS) refers to services that are flexible, wrap-around supports designed to fill medical and socially determined health gaps. The services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. To be eligible for CS, members must meet specific eligibility requirements. Contracted community-based CS providers will provide services to approved members.

Referral source information	
External referral by (select one):	<input type="checkbox"/> Hospital <input type="checkbox"/> PMG <input type="checkbox"/> PCP <input type="checkbox"/> Clinic <input type="checkbox"/> ECM provider <input type="checkbox"/> Other
Referring individual name:	
Referring organization name:	
Referrer phone number:	
Referrer email address:	
Member aware of referral:	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Referring entity:	
Refer to Organization Name:	
Refer to Phone Number:	
Refer to Email Address:	
Preferred Community Support Start Date:	

Member information			
Member name:			
Member Medi-Cal Managed Care (Medi-Cal) client ID # (CIN):		Member DOB:	
Member address:			
Member primary phone number:		Best time to contact:	
Member preferred:			
Caregiver name:		Caregivers Alternate phone	



		number (if available):	
Care Manager name:		Care Manager contact information: Phone/fax/email:	
Diagnosis Code:			

Medically tailored meals/Medically supportive food

This service provides up to three meals per day and/or medically supportive food (for example, a voucher) and nutrition services for up to 12 weeks or longer if medically necessary. Meals are not provided to respond solely to food insecurity.

Exclusions: receiving other meal delivery services from local, state, or federally funded programs.

Does this member have a chronic condition in the following categories? <input type="checkbox"/> Diabetes <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Stroke <input type="checkbox"/> Chronic lung disorders <input type="checkbox"/> Human Immunodeficiency Virus (HIV) <input type="checkbox"/> Cancer <input type="checkbox"/> Gestational diabetes, or other high risk perinatal conditions <input type="checkbox"/> Chronic or disabling mental/behavioral health disorders <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above
Does this member have extensive care coordination needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are they being discharged from the hospital or skilled nursing facility or at high risk of hospitalization or nursing facility placement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Request: <input type="checkbox"/> Meals
Meal Provider: <input type="checkbox"/> Mom’s Meals <input type="checkbox"/> GA Foods <input type="checkbox"/> Mama’s Kitchen <input type="checkbox"/> Roots Food Group Holdings Inc. <input type="checkbox"/> Serene Health IPA <input type="checkbox"/> WellSpace Health

<p>Types of Meals:</p> <p><input type="checkbox"/>Diabetic <input type="checkbox"/>Kosher <input type="checkbox"/>Low Sodium <input type="checkbox"/>Vegan <input type="checkbox"/>Vegetarian <input type="checkbox"/>Low Calorie</p> <p><input type="checkbox"/>Other _____</p> <p>_____</p> <p><input type="checkbox"/>Restrictions:</p> <p>_____</p> <p><input type="checkbox"/>Allergies:</p> <p>_____</p> <p><input type="checkbox"/>Comments:</p> <p>_____</p> <p>_____</p> <p>*Community Support Members can receive up to 2 meals per day for up to 12 weeks. **Nutritional Assessment/Counseling session 1 per 12 weeks.</p>

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation/office visit notes with diagnosis or identification of chronic illness requiring special diet
- Skilled nursing discharge plan
- Documentation from support agencies indicating services/supports member needs or receives
- ED, Inpatient, Skilled Nursing discharge paperwork
- Medication/treatment orders

Nursing facility diversion services to an assisted living facility

This service is for members residing in the community, who are at risk of imminent need for nursing facility level of care and are willing to reside in an assisted living facility as an alternative to long term placement in a nursing facility. Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board.

Is the member interested in remaining in the community? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are they willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Do they meet minimum criteria for nursing facility level of care (unable to complete ADLs without assistance)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are they able to pay for own living expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation from support agencies indicating services/supports member needs or receives



- Documentation/office visit notes with diagnosis and identification of frailty
- Medication/treatment orders

Community transition services/nursing facility transition to a home or assisted living facility

Non-recurring set up expenses for members who are transitioning from a licensed facility to a living arrangement in a private residence or assisted living facility where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable the member to establish a basic household that does not include room and board.

Is the member currently residing in a nursing facility and receiving medically necessary nursing facility services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have they lived 60 or more days in a nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Are they interested in moving back into the community? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are they willing and able to reside safely in a home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are they willing to live in an assisted living facility with appropriate and cost-effective supports and services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are they willing and able to pay for own living expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No

Documentation: It's recommended you upload one or more of the following documents with this request:

- Skilled nursing discharge plan/paperwork
- Documentation from support agencies indicating services/supports member needs or receives
- Documentation/office visit notes with diagnosis and identification of frailty
- Documentation of home modifications/services completed
- Medication/treatment orders

Environmental accessibility adaptations (EAA), also known as home modifications

Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a member, or enable the member to function with greater independence in the home, without which the member would require institutionalization. Lifetime cap is \$7500.

Is the member at risk for institutionalization in a nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the home owned, leased, rented, or occupied by the member? <input type="checkbox"/> Yes <input type="checkbox"/> No
This request is for <i>(check all that apply)</i> : <input type="checkbox"/> Equipment <input type="checkbox"/> Home modification <input type="checkbox"/> Personal emergency response system (PERS)

Documentation: It's recommended you upload one or more of the following documents with this request:

- Physical therapy/durable medical equipment evaluation documenting safety needs
- Documentation/office visit notes with diagnosis and identification of frailty

Asthma remediation services, also known as asthma trigger remediations

Physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the member or enable the member to function in the home while reducing acute asthma episodes that could result in the need for emergency services and hospitalization. Lifetime cap is \$7500.

The member has poorly controlled asthma documented by: <input type="checkbox"/> Emergency department visit <input type="checkbox"/> Hospitalization <input type="checkbox"/> Two sick/urgent care visits in past 12 months <input type="checkbox"/> Score of ≤ 19 on asthma control test
Is the home owned, leased, rented, or occupied by the member? <input type="checkbox"/> Yes <input type="checkbox"/> No
This request is for (<i>check all that apply</i>): <input type="checkbox"/> Equipment <input type="checkbox"/> Home modification

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation of asthma diagnosis from service provider, PCP, or specialists
- Pulmonary function tests
- Prescriptions
- Asthma treatment plan
- List of asthma medications

Day habilitation

Provided in home or out-of-home, non-facility setting. Programs designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills to remain in their natural environment.

What is the member's housing status? <input type="checkbox"/> Homeless <input type="checkbox"/> Chronically homeless <input type="checkbox"/> At risk of homelessness <input type="checkbox"/> Entered housing in the last 24 months
The member is participating in (<i>check one or both</i>): <input type="checkbox"/> Housing navigation

<input type="checkbox"/> Housing tenancy and sustaining services
The member would benefit from the following training:
<input type="checkbox"/> Use of public transportation
<input type="checkbox"/> Personal skills development in conflict resolution
<input type="checkbox"/> Community participation
<input type="checkbox"/> Developing and maintaining interpersonal relationships
<input type="checkbox"/> Daily living skills (cooking, cleaning, shopping, money management)
<input type="checkbox"/> Community resources awareness such as police, fire, or local services to support independence
<input type="checkbox"/> Selecting and moving into a home
<input type="checkbox"/> Locating and choosing suitable housemates
<input type="checkbox"/> Locating household furnishings
<input type="checkbox"/> Managing personal financial affairs
<input type="checkbox"/> Recruiting, screening, hiring, training, supervising, and dismissing personal attendants
<input type="checkbox"/> Dealing with and responding appropriately to governmental agencies and personnel
<input type="checkbox"/> Asserting civil and statutory rights through self-advocacy
<input type="checkbox"/> Building and maintaining interpersonal relationships, including circle of support
<input type="checkbox"/> Other

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation of housing status by service providers, PCP, specialists, or outreach providers
- Documentation of participation in housing navigation or housing tenancy and sustaining services

Personal care and homemaker services

Assistance with activities of daily living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Can include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Homemaker or chore services include help with tasks such as cleaning, shopping, and laundry. Services aid members who could not remain in their homes. May request urgent/expedited review.

The member is:
<input type="checkbox"/> At risk for hospitalization or institutionalization in a nursing facility
<input type="checkbox"/> Has functional deficits with no other support system
<input type="checkbox"/> Is approved for In-Home Supportive Services (IHSS), but needs additional support
Is the member willing to be referred to In-Home Supportive Services if applicable? <input type="checkbox"/>
Yes <input type="checkbox"/> No
The member:

- Requires additional In-Home Supportive Services hours beyond the 283-hour maximum per month
- Is in a waiting period for In-Home Supportive Services review including prior to and up through IHSS application date
- Not eligible for IHSS, but requires services to avoid a short-term stay in a skilled nursing facility (not to exceed 60 days)

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation/office visit notes with diagnosis and identification of frailty
- Assessments identifying members physical needs
- Documentation from support agencies indicating services/supports member needs or receives
- Physical therapy/durable medical equipment evaluation documenting safety needs
- Medication/treatment orders

Recuperative care or medical respite care

Short-term residential care for members who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, includes interim housing with bed and meals and ongoing monitoring of the members medical or behavioral health condition. Limited to continuous 90 day stay.

The member:

- Is at risk of hospitalization
- Is post-hospitalization and needs to heal from injury or illness
- Lives alone with no formal support
- Faces housing insecurity or has housing that would jeopardize his or her health and safety without modification

Documentation: It's recommended you upload one or more of the following documents with this request:

- Emergency department, inpatient, or skilled nursing discharge paperwork
- Documentation of homelessness by service providers, PCPs, specialists, or outreach providers
- Documentation of entries/exits from shelters
- Documentation from any support agency indicating services/supports member needs
- Documentation/office visit notes with diagnosis and identification of frailty
- Assessment determining limitations in ADLs
- Medication/treatment orders

Short-term post hospitalization housing

This service provides housing for members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical, psychiatric, or substance use disorder recovery immediately after exiting one of the following:

- Inpatient hospital
- Residential alcohol or drug abuse recovery or treatment facility
- Residential mental health treatment facility
- Correctional facility
- Nursing facility
- Recuperative care

The member must also be receiving housing navigation services. May request urgent/expedited review. Lifetime benefit one-time and not to exceed duration of six months.

Are they exiting any of the following: <input type="checkbox"/> Recuperative care <input type="checkbox"/> Inpatient hospital stay <input type="checkbox"/> Residential alcohol or drug abuse recovery or treatment facility <input type="checkbox"/> Residential mental health treatment facility <input type="checkbox"/> Correctional facility
What is the member's housing status? <input type="checkbox"/> Homeless <input type="checkbox"/> Chronically homeless <input type="checkbox"/> At risk of homelessness
Is the member currently receiving housing navigation services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Documentation: It's recommended you upload one or more of the following documents with this request:

- ED or inpatient discharge paperwork
- Documentation of homelessness by service providers, PCP, specialists, or outreach providers
- Documentation of member participating in housing transition navigation services

Respite services

Respite services for non-paid caregivers of members only. Provided on a short-term basis due to the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. Services can be provided in the home or a facility. May request urgent/expedited review.

The member (<i>check all that apply</i>):

<input type="checkbox"/> Resides in the community
<input type="checkbox"/> Requires assistance with activities of daily living
<input type="checkbox"/> Is dependent on non-paid caregivers
Does the caregiver require relief to avoid institutional placement of member? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is member willing to receive respite care in home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is member willing to receive respite care in a facility? <input type="checkbox"/> Yes <input type="checkbox"/> No

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation/office visit notes with diagnosis and identification of frailty
- Documentation from support agencies indicating services/supports member needs or receives
- Attestation from unpaid caregiver(s) requesting services

Housing transition navigation services

Does not include room and board. Includes tenant screening and housing assessment, housing support plan, searching for housing, assistance with securing housing (applications/documentation), benefit advocacy, identifying/securing resources for rent subsidy and expenses, assisting with reasonable accommodations, landlord education/engagement, ensuring living environment safety/ move-in readiness, advocacy with landlords, move-in support, housing support crisis plan, transportation resources, and environmental modifications as necessary.

What is the member's housing status?
<input type="checkbox"/> Homeless
<input type="checkbox"/> Chronically homeless
<input type="checkbox"/> At risk of homelessness

Documentation: It's recommended you upload one or more of the following documents with this request:

- Documentation of homelessness or at risk for homelessness by service providers, PCPs, specialists, or outreach providers
- Documentation of entries/exits from shelters
- Notices from current landlord
- Financial Statements

Housing tenancy and sustaining services

Services to maintain a safe and stable tenancy once housing secured. Services can include the identification and intervention of behaviors that jeopardize housing, education on role/rights/ responsibilities of tenant and landlord, coaching on maintaining and developing landlord/property managers, assistance with landlord/neighbor disputes, advocacy/linkage

to community resources, benefits advocacy, assistance with annual housing recertification, review/update/modify housing support and crisis plan, assistance with lease compliance, health and safety visits, and independent living and life skills.

Is the member receiving housing navigation services? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is the member's housing status? <input type="checkbox"/> Homeless <input type="checkbox"/> Chronically homeless <input type="checkbox"/> At risk of homelessness

Documentation: It's recommended you upload one or more of the following documents with this request:

- Housing support plan
- Lease agreements

Housing deposit services

Identification, coordinating, securing, or funding one-time services and modifications necessary to enable the member to establish a basic household. Funding to support security deposits, set-up fees/ deposits for utilities, first months and deposit, services necessary for member's health and safety, and goods/medically necessary adaptive aides to preserve the member's health and safety in the home. Does not include provisions beyond first and last month's rent. Lifetime maximum of \$5000.

What is the member's housing status? <input type="checkbox"/> Homeless <input type="checkbox"/> Chronically homeless <input type="checkbox"/> At risk of homelessness <input type="checkbox"/> Prioritized for a permanent supportive housing unit or rental subsidy resource through the local CES

Documentation: It's recommended you upload one or more of the following documents with this request:

- Lease agreements
- Utility bill/deposit agreement
- Financial statements

Sobering Centers

Sobering Centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering Centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment in which to become sober.

Documentation: It is expected that you upload all the pertinent documentation listed below to support your referral request:

- Intake and screening information to support provided services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.
- Direct coordination with the county behavioral health agency **is required** and warm hand-offs for additional behavioral health services are strongly encouraged.
- Screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.

Send Community Support Referral Request Form

Email: AetnaBetterHealthCACM@Aetna.com

Fax: San Diego: 1-866-584-4450 or Sacramento: 1-866-489-7441

Phone: 1-855-772-9076