Community Supports – Approval Request Form
(for Personal Care & Homemaker Services)

The Alameda Alliance for Health (Alliance) Community Supports – Approval Request Form *(for Personal Care & Homemaker Services)* is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for personal care & homemaker services, please complete the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly or type in all the fields below.
2. Attach a clinical summary and/or supporting documentation (e.g., clinic notes, hospital discharge summary, etc.) for personal care & homemaker services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Office Contact Name: _____ Date of Request: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Primary Diagnosis Requiring Personal Care & Homemaker Services (including ICD-10 Code(s)):

_____

☐ Confirm (to the best of your knowledge) that the member is not receiving duplicative support from other state, local, or federally funded programs, and these programs have been considered first before using Medi-Cal funding.

Is an interpreter needed?

☐ Yes

If yes, what is the preferred language? _____

☐ No

Member's Qualifying Condition(s) (please select all that apply, the member must meet at least one (1) to be eligible):

☐ Member is at risk for hospitalization, or institutionalization in a nursing facility; or
☐ Member has a functional deficit and no other adequate support system; or
☐ Member has been approved for In-Home Supportive Services. Eligible criteria can be found at **www.cdss.ca.gov/In-Home-Supportive-Services**

Requesting Services (please select all that apply, supporting documentation is required for approval):

☐ Member currently has approved county In-Home Supportive Services hours and additional hours are required and In-Home Supportive Services benefits are exhausted.
☐ A referral to In-Home Supportive Services has already occurred and the member is in the In-Home Supportive Services waiting period.
☐ Member is not eligible to receive In-Home Supportive Services and this assistance will help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).
☐ There is an individual in the member's life who can provide reliable caregiving for the member.

Name of Potential Caregiver: _____

Phone Number of Potential Caregiver: _____

☐ There is **not an** individual in the member's life who can provide reliable caregiving for the member.

Rendering Provider (please select only one (1)):

☐ 24-Hour Home Care (NPI Number: 1376797035)
☐ Omatochi (NPI Number: 1669058558)