CalAIM Community Supports – Referral Form

This Alameda Alliance for Health (Alliance) CalAIM Community Supports – Referral Form is confidential. Filling out this form will help us better serve our members. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all the fields in Sections 1 and 2 below.
2. In Section 3, please select the boxes for the Community Supports services that the member is interested in receiving. Select all required checkboxes for the selected services prior to submission.
3. Fax or send by secure email the completed form and any supporting documentation to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Community Supports Department at **1.510.747.4545**.

Referral Date: _____

SECTION 1: REFERRAL INFORMATION

Last Name: _____ First Name: _____

Agency or Relationship to Member: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____

Alliance Member ID Number: _____ Client Index Number (CIN): _____

Primary Care Provider (PCP) Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Email: _____

Preferred Written Language: _____

Preferred Spoken Language: _____

Is the member currently in the hospital? ☐ Yes ☐ No

SECTION 3: COMMUNITY SUPPORTS SERVICES	
Housing Services	
Service Type	**Requirements**
☐ **Housing Deposit –** Identifies, coordinates, and funds move-in costs and services for a basic household, excluding room and board. Members must be receiving Housing Transition Navigation Services.	Please select all that apply: ☐ Member is receiving Housing Transition Navigation Services. Housing Navigation Provider: _____ *(Additional documentation will be requested from this provider.)* ☐ Member is prioritized for permanent supportive housing or rental subsidy through the local homeless CES. ☐ Member meets the U.S. Department of Housing and Urban Development (HUD) definition of homelessness. Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Housing Tenancy and Sustaining Services –** Provides education, coaching, and support to maintain a safe and stable tenancy once housing is secured.	Please select all that apply: ☐ Member meets criteria under Housing Transition Navigation Services (please select appropriate boxes under **Housing Navigation**). ☐ Member received Housing Transition Navigation Services. Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Housing Transition Navigation Services –** Assist members with obtaining housing and preparing for move-in.	Please select only one (1): ☐ Member is at risk of homelessness with significant barriers to housing that meet at least one (1) of the following: • Has one (1) or more serious chronic conditions. • Has a serious mental illness. • Is at risk of institutionalization or overdose or requires residential services because of a substance use disorder or has a serious emotional disturbance (children and adolescents). • Is receiving Enhanced Care Management (ECM). • Is a transition-age youth with significant barriers to housing stability, such as one (1) or more convictions, a history of foster care, involvement with the juvenile justice or criminal system, and/or was a victim of trafficking or domestic violence. ☐ Member is prioritized for permanent supportive housing or rental subsidy through the local homeless Coordinated Entry System (CES). ☐ Member meets the HUD definition of homelessness or at risk for homelessness.

SECTION 3: COMMUNITY SUPPORTS SERVICES (CONT.)	
In-Home Services	
Service Type	**Requirements**
☐ **Asthma Remediation** – Provides information for members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and provides needed equipment.	Please select all that apply: ☐ Member had an emergency department visit or hospitalization in the past 12 months. ☐ Member had two (2) sick or urgent care visits in the past 12 months. ☐ Member has a score of 19 or lower on the Asthma Control Test. ☐ PCP has documented the medical need for this service and will provide documentation upon request. Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Environmental Accessibility Adaptations** – Provides physical adaptations to a home that are necessary to ensure the health, welfare, and safety of members, or that enable members to remain in their home.	Request for a Personal Emergency Response System (PERS)? ☐ Yes ☐ No Please select all that apply: ☐ Member is at risk for institutionalization in a nursing facility. **AND** ☐ Member has discussed needing a home modification with their primary care provider (PCP). ☐ PCP has documented the medical need for this service and will provide documentation upon request. Member received this service before: ☐ Yes ☐ No ☐ Unsure

SECTION 3: COMMUNITY SUPPORTS SERVICES (CONT.)	
In-Home Services (cont.)	
Service Type	**Requirements**
☐ **Medically-Tailored Meals** – Provide members with medically-tailored meals at home after discharge from a hospital or nursing home.	Please select all that apply: ☐ Member has extensive care coordination needs. ☐ Member is at high risk of hospitalization or nursing facility placement. ☐ Member is currently in the hospital or nursing facility and medically-tailored meals are a part of the discharge plan. (This will trigger an expedited request.) Please list the member's chronic conditions: ☐ Member is interested in medically-tailored grocery boxes ☐ Member is interested in Nutritional Counseling ☐ Member is interested in pre-made medically-tailored meals ☐ Member is on a special diet. If selected, please describe: ☐ Member is receiving other meal delivery services from local, state, or federally funded programs. ☐ Member was recently discharged from the hospital or skilled nursing facility. If selected, please describe: Member has a refrigerator: ☐ Yes ☐ No

SECTION 3: COMMUNITY SUPPORTS SERVICES (CONT.)	
In-Home Services (cont.)	
Service Type	**Requirements**
☐ **Personal Care and Homemaker Services** – Provide members who need help with activities of daily living (ADLs) with personal care and homemaker services.	Please select all that apply: ☐ Member has functional deficits and no adequate support system. ☐ Member is at risk for hospitalization or institutionalization in a nursing facility. Please select only one (1): ☐ Member has applied for IHSS and is waiting to have the assessment completed. ☐ Member is approved for In-Home Supportive Services (IHSS) **and** has requested an increase in hours that is still pending. Family member or friend interested in becoming a caregiver: ☐ Yes ☐ No
☐ **Respite Services** – Provides respite services to caregivers of members who require intermittent temporary supervision. This service is distinct from medical respite or recuperative care and provides rest for the caregiver only. Limit is 336 hours per year.	Complete all sections below: In-home respite services are provided to the member in their own home or another location being used as the home. ☐ Dependent on a qualified caregiver and without one, the member would need to be in a nursing facility. Member has specific dates and times for needing a respite caregiver: Start Date: _____ End Date: _____ Hours: _____ Member has other services that provide a caregiver (please select all that apply): ☐ Community-Based Adult Services (CBAS) ☐ In-Home Supportive Services (IHSS) ☐ Private Caregiver ☐ Regional Center

SECTION 3: COMMUNITY SUPPORTS SERVICES (CONT.)	
Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission (cont.)	
Service Type	**Requirements**
☐ **Community Transition Services** – Provides nursing facility transition to a home.	Eligibility criteria: • Member is currently receiving medically necessary nursing facility Level of Care (LOC) services and, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services • Member is interested in moving back to the community. • Member is willing and able to reside safely in the community with appropriate and cost-effective supports and services. • Member resided 60+ days in a nursing home or medical respite setting. Member meets **ALL** criteria in this section: ☐ Yes ☐ No Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Nursing Facility Diversion to Assisted Living Facility** – Transition members who, without this support, would need to reside in a nursing facility and instead transition them into a Residential Care Facility for Elderly (RCFE) or Adult Residential Facility (ARF).	Eligibility criteria: • Member is currently receiving medically necessary nursing facility LOC services or meets the minimum criteria to receive those services in an assisted living facility. • Member is interested in remaining in the community. • Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services. Member meets **ALL** criteria in this section: ☐ Yes ☐ No Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Nursing Facility Transition to Assisted Living Facility** – Transition members from a nursing facility into a Residential Care Facility for Elderly or Adult Residential Facility.	Eligibility criteria: • Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services. • Member is willing to live in an assisted living setting as an alternative to a nursing facility. • Member resided 60+ days in a nursing facility. Member meets **ALL** criteria in this section: ☐ Yes ☐ No Member received this service before: ☐ Yes ☐ No ☐ Unsure

SECTION 3: COMMUNITY SUPPORTS SERVICES (CONT.)	
Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission (cont.)	
Service Type	**Requirements**
☐ **Recuperative Care –** Provides short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury, illness, or mental health condition.	Please select only one (1): ☐ Member faces housing insecurity or has housing that would jeopardize the member's health and safety without modification. ☐ Member is at risk of homelessness with significant barriers to housing that meet at least one (1) of the following: • Has a serious mental illness. • Has one (1) or more serious chronic conditions. • Is at risk of institutionalization or overdose or requires residential services because of a substance use disorder or has a serious emotional disturbance (children and adolescents). • Is a transition-age youth with significant barriers to housing stability, such as one (1) or more convictions, a history of foster care, involvement with the juvenile justice or criminal system, and/or been a victim of trafficking or domestic violence. • Is receiving ECM. ☐ Member is at risk of hospitalization or is post-hospitalization. ☐ Member lives alone with no formal supports. ☐ Member meets the HUD definition of homeless or at risk of homelessness. Please attach the Recuperative Care or Short-Term Post-Hospitalization Housing (STPHH) Referral Form.