

Community Supports Member Referral Form

Keeping Members at Home and Chronic Conditions

General referral Information

Kaiser Permanente **ONLY** accepts referrals for **Medi-Cal Members** whose coverage is assigned to Kaiser Permanente.

Kaiser Permanente employs a “No Wrong Door” approach for Enhanced Care Management (ECM), Complex Case Management (CCM), Community Health Worker (CHW), and Community Supports (CS) referrals – referrals should be submitted to the Member’s Managed Care Plan (MCP) and will be accepted from all points of care within the continuum.

What are Community Support services?

CS services improve the health and well-being of MCP Members by addressing Members’ health-related social needs and helping them live healthier lives and avoid higher, costlier levels of care. They are non-medical services (e.g., housing navigation, asthma remediation) provided as cost-effective alternatives to traditional medical services and settings. CS availability varies by county.

Time-limited coverage of housing-related CS services are intended to help Members experiencing or at risk of homelessness address their health-related social needs, support their transition to housing stability, and realize the significant improvements in health that have been shown to result from stable housing.

Which Community Support services are included in this referral form?

- Respite Services (Caregiver Respite)
- Assisted Living Facility Transitions
- Community or Home Transition Services
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals/Medically-Supportive Food
- Asthma Remediation

Instructions

Complete all required fields to the best of your ability and submit this form via secure email to the appropriate region. Incomplete or outdated forms may cause processing delays. The most updated referral forms can be found on the Provider Portal.

	Northern California	Southern California
Email Referrals	REGMCDURNS-KPNC@KP.org	RegCareCoordCaseMgmt@KP.org
Provider Portal	NCAL - Provider Portal	SCAL Provider Portal

SECTION A

Fields marked with an asterisk (*) are mandatory

Is the person being referred a Kaiser Permanente (KP) Medi-Cal Member?*

- Yes, this is a Kaiser Permanente Medi-Cal Member
 No, STOP, do NOT proceed. Please send referral to their assigned Medi-Cal Managed Care Plan

Referral Source Information

Date of Referral*	Referrer Name*
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)*	
Referrer/Referring Organization Address* (Street, City, State, Zip Code)	
Referrer Email*	Referrer Phone Number*
Referrer Relationship to Member? Select the <u>ONE</u> that applies*: <input type="checkbox"/> Medical provider <input type="checkbox"/> Social services provider <input type="checkbox"/> Member/family <input type="checkbox"/> Other please specify:	
External referral by? Select the <u>ONE</u> that applies*: <input type="checkbox"/> Network Lead Entity (NLE) <input type="checkbox"/> ECM, CHW or CS vendor – select the one you are affiliated with: <input type="checkbox"/> Full Circle Health <input type="checkbox"/> Independent Living Systems <input type="checkbox"/> Partners in Care <input type="checkbox"/> Foodsmart <input type="checkbox"/> Mom's Meals <input type="checkbox"/> Managed Care Plan (MCP) <input type="checkbox"/> Other health care provider <input type="checkbox"/> Mental health care provider <input type="checkbox"/> Hospital or Emergency Room care team <input type="checkbox"/> County or other government organization <input type="checkbox"/> Schools/Local Education Agencies (LEAs) <input type="checkbox"/> Other community-based provider <input type="checkbox"/> Legal aid organizations <input type="checkbox"/> Justice involved organizations <input type="checkbox"/> Other, please specify:	

SECTION A

Fields marked with an asterisk (*) are mandatory

Member Information

Member Name (First Name, Middle Initial, Last Name)*	
Member Date of Birth *	Member Phone Number *
Member Mailing Address * (Street, City, State, Zip Code)	
Member's Kaiser Permanente MRN * (or Medi-Cal CIN if MRN is unknown)	
Caregiver/Support Person Name	
Caregiver/Support Person Contact (Email/Phone Number)	

Current Service Usage

1.) Is the Member currently receiving any of the following services? Select ALL that apply:

A.) ECM – If selected, please include the following information:

Provider Name: _____

Email or Phone Number: _____

B.) CCM

C.) CHW

D.) CS Services

<input type="checkbox"/> Respite Services (Caregiver Respite) <input type="checkbox"/> Assisted Living Facility Transitions <input type="checkbox"/> Community or Home Transition Services <input type="checkbox"/> Personal Care and Homemaker Services <input type="checkbox"/> Environmental Accessibility Adaptations (Home Modifications) <input type="checkbox"/> Medically Tailored Meals/Medically-Supportive Food <input type="checkbox"/> Sobering Centers	<input type="checkbox"/> Asthma Remediation <input type="checkbox"/> Housing Transition Navigation Services <input type="checkbox"/> Housing Deposits <input type="checkbox"/> Housing Tenancy and Sustaining Services <input type="checkbox"/> Day Habilitation Programs <input type="checkbox"/> Recuperative Care (Medical Respite) <input type="checkbox"/> Short-Term Post-Hospitalization Housing <input type="checkbox"/> Transitional Rent
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Attestation*

By checking this box, you confirm that all information provided on this form is accurate and has been verified. You also confirm that the Member has consented to participate in the program(s) to which they are being referred and that you can provide supporting documentation if requested.

SECTION B: COMMUNITY SUPPORT SERVICES

1. Respite Services (Caregiver Respite)

Important Information – Please Read

Description: Provides short-term relief for caregivers of Members who are at home or in an approved facility.

Key Information:

- Service limit is up to 336 hours per calendar year, unless an exception is made.
 - Hours beyond the 336-hour calendar year limit may be approved when there's been a change in the caregiver situation (such as medical treatment and/or hospitalization) that leaves the Member without support.

1.1) THE MEMBER MUST MEET ONE OF THE FOLLOWING CRITERIA.

→ Select the one that applies:

- A)** Lives in the community and is compromised with their Activities of Daily Living (ADLs) and therefore is dependent upon a caregiver (paid or unpaid) for most of their support to avoid institutional placement;

OR

- B)** Other subsets include children who belong to any of the following categories:
 - Previously covered for Respite Services under the Pediatrics Palliative Care Waiver
 - Foster care program beneficiaries
 - Members enrolled in either California Children's Services
 - Genetically Handicapped Persons Program
 - Members with Complex Care Needs

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

2. Assisted Living Facility Transitions (Page 1 of 2)

Important Information – Please Read

Description: Assisting Members who are residing at home or in a nursing facility, that need nursing facility level of care with transitioning to an assisted living facility (ALF) to avoid institutionalization.

Key Information:

- **Before** submitting a referral:
 - Consider other care options first, such as: ECM, Community-Based Adult Services, In-Home Supportive Services, Personal Care and Homemaker Services, Caregiver Respite, etc.
 - If the Member lives in an Assisted Living Waiver (ALW) county, prioritize placement in an ALW- participating ALF. Ensure the Member knows the contact person supporting their placement.
- This Community Support service includes two components:
 - **Time-Limited transition services and expenses** – Assesses and supports the Member in moving into and establishing residency in an ALF.
 - **Ongoing ALF services** – Provides continued support for the Member in maintaining nursing facility level of care needs and residency at the ALF.
- Members may be eligible if receiving facility level health care services on an acute or post-acute care basis (e.g. hospitalization or a short-term skilled nursing facility stay).
- Members are strongly encouraged to visit their Primary Care Provider (PCP) if they have not done so in the past year, to ensure their current healthcare needs are being addressed.
- An in-person assessment **is required** to determine eligibility and confirm clinical status for both components.
- Members must be **authorized for Time-Limited transition services and expenses before initiating Ongoing ALF services, even if they are already living in an ALF.** This ensures appropriate placement and competition of the required assessments.
- **Members are responsible for paying for room and board at the facility.** Financial Documents are **required** to assess proof of income and sustainability of placement at the time of the initial assessment, and every 6 months thereafter at the time of reauthorization.
- This service is not intended for Member's who are already living in an ALF and wish to transfer to another ALF.

2.1) WHICH SERVICE IS THE MEMBER BEING REFERRED FOR?

→ Select the one that applies:

- A)** Time-Limited transition services and expenses
- B)** Ongoing ALF services (**Note:** Member **MUST** first be approved for Time-Limited transition services and expenses before starting Ongoing ALF services)

SECTION B: COMMUNITY SUPPORT SERVICES

2. Assisted Living Facility Transitions (Page 2 of 2)

2.2) WHERE IS THE MEMBER CURRENTLY LIVING?

→ Select the one that applies:

A) In a Skilled Nursing Facility (SNF)

→ To be eligible, Member must meet all of the following criteria:

- Has lived in a nursing facility for 60 days or more; **AND**
- Is willing to live in an ALF setting instead of nursing facility; **AND**
- Is able to reside safely in an ALF

OR

B) At home or in public subsidized housing

→ To be eligible, Member must meet all of the following criteria:

- Is interested in remaining in the community; **AND**
- Is willing and able to reside safely in an ALF; **AND**
- Meets the nursing facility level of care (LOC) criteria and, instead of going into a facility, chooses to stay in the community and continue to receive medically necessary LOC services in an ALF

OR

C) In an Assisted Living Facility (ALF) or a Board and Care Facility

→ To be eligible, the Member must meet all of the following criteria:

- Is interested in remaining in the community; **AND**
- Is willing and able to reside safely in an ALF; **AND**
- Meets the nursing facility level of care (LOC) criteria and, instead of going into a facility, chooses to stay in the community and continue to receive medically necessary LOC services in an ALF

→ If selected, please provide the following information on the ALF/Board and Care:

Facility Name:

Address (Street, City, State, Zip Code):

Current cost and how it's being covered?

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

3. Community or Home Transition Services (Page 1 of 2)

Important Information – Please Read

Description: Help with non-recurring costs to move from licensed facility to private residence.

Key Information:

- The Member **cannot receive** any of the following services at the same time as this Community Support:
 - California Community Transitions (CCT) program,
 - Home & Community Based Alternatives (HCBA) Waiver, and/or
 - The Multipurpose Senior Services Program (MSSP)
- This Community Support service includes two components:
 - **Time-Limited transition services and expenses** – Assesses and supports the Member in moving from a licensed facility to a private residence or public subsidized housing.
 - **Non-recurring set-up expenses** – Provides support to the Member for necessary one-time expenses required to establish a basic household, not including room and board.
- An in-person assessment **is required** to confirm eligibility and ensure the Member can reside safely in the community with appropriate and cost-effective supports and services.

3.1) TO BE ELIGIBLE, THE MEMBER MUST MEET ALL OF THE FOLLOWING CRITERIA:

- Member is receiving medically necessary nursing facility Level of care (LOC) services and in lieu of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility LOC services; **AND**
- Member has lived 60+ days in a nursing home and/or Recuperative Care setting; **AND**
- Member is interested in moving back to the community; **AND**
- Member is able to reside safely in the community with appropriate and cost-effective supports and services

3.2) MEMBER IS CURRENTLY RESIDING IN:

→ Select the one that applies and provide the following information on the facility:

- Nursing Facility
- Recuperative Care facility

Facility Name:

Address (Street, City, State, Zip Code):

Phone Number:

SECTION B: COMMUNITY SUPPORT SERVICES

3. Community or Home Transition Services (Page 2 of 2)

3.2) CONTINUED

→ Provide the following information on the facility:

Explain how the Member would be able to reside safely in the community:

Facility admission date:

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

4. Personal Care and Homemaker Services (Page 1 of 2)

Important Information – Please Read

Description: Provides in-home support with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

Key Information:

- If the Member meets the IHSS referral criteria, they must be referred to the In-Home Supportive Services (IHSS) program. Personal Care and Homemaker Services (PCHS) cannot be utilized as a substitute for the IHSS program.
- If the Member is currently receiving PCHS and their condition changes, they must be referred to IHSS for a reassessment. The Member may continue receiving PCHS while waiting for the IHSS reassessment decision on possible adjustment to hours.
- If the Member needs help applying for IHSS, please submit a referral to ECM, CCM, or CHW for support.
- Members enrolled in Home and Community Based Alternatives (HCBA) Waiver program or receiving/eligible for Waiver Personal Care services (WPCS) are not eligible for PCHS. However, Members on the waitlist for HCBA Waiver may receive PCHS while they are awaiting HCBA waiver approval.

4.1) TO BE ELIGIBLE, THE MEMBER MUST MEET ONE OF THE FOLLOWING CRITERIA.

→ Select the one that applies:

- A)** Member is at risk of hospitalization or institutionalization in a nursing facility; **OR**
- B)** Member has functional deficits and no other adequate support system; **OR**
- C)** Member approved for IHSS

SECTION B: COMMUNITY SUPPORT SERVICES

4. Personal Care and Homemaker Services (Page 2 of 2)

4.2) WHAT IS THE MEMBER'S IHSS APPLICATION STATUS?

→ Select the one that applies:

- A)** Member has applied for IHSS and is waiting for a decision;
→ If selected, please provide the following information.

IHSS application date:

OR

- B)** Member is currently receiving IHSS, needs additional IHSS hours, the reassessment request is pending, and the caregiver is needed for support in the meantime;
→ If selected, please provide the following information.

**IHSS reassessment
application date:**

**Current approved
IHSS hours per month:**

OR

- C)** Member has been approved for the maximum IHSS hours, but needs additional support.
→ If selected, please explain why additional support is needed.

OR

- D)** Member is **not** eligible for IHSS and needs services to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).
→ If selected, please explain the Member's clinical status and why these services are needed.

OR

- E)** Member is not eligible for IHSS, but is on the waitlist for the approval of the HCBA waiver to receive WPCS.

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

5. Environmental Accessibility Adaptations (Home Modifications)

Important Information – Please Read

Description: Physical home adaptations for member’s health, welfare, safety, and independence.

Key Information:

- This service is payable up to a total lifetime maximum of \$7,500.
- If Durable Medical Equipment (DME) is available and would accomplish the same goals of independence and avoiding institutional placement, it should be considered as the first option.
 - The Member should contact their Kaiser Permanente physician to discuss available options and determine coverage based on their clinical needs and benefit plan; If requesting DME, do NOT complete this referral form.
- If the Member is eligible for Home Modifications, a home visit **MUST** be conducted to confirm the appropriateness and feasibility of any requested modifications and/or equipment.
 - **EXCEPT** for PERS requests.
- Written consent is **required** from **both** the Member and the property owner/landlord before commencement of a physical adaptation or equipment that is physically installed in the home.

5.1) IS THE MEMBER AT RISK OF BEING INSTITUTIONALIZED IN A NURSING FACILITY?

- No – If selected, do not continue, Member is not eligible for Home Modifications
- Yes – If selected, please continue and question in this section 5.2 and 5.3

5.2) WHAT IS THE MEMBER REQUESTING?

→ Select all that apply:

- Home Modification/Adaptation (such as doorway widening to accommodate a wheelchair, tub cut, roll-in shower)
- Personal Emergency Response System (also known as PERS)
- Other, please specify:

5.3) DOES THE MEMBER OWN THE HOME WHERE THE MODIFICATION IS BEING REQUESTED?

→ Select the one that applies:

- A)** Yes
- B)** No

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

□ 6. Medically Tailored Meals/Medically Supportive Food (Page 1 of 2)

Important Information – Please Read

Description: Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition sensitive and will lead to improved health outcomes and reduced unnecessary costs.

Key Information:

- This service is **not** for food insecurity.
- Nutrition assessment and counseling is provided.
- This service is intended for short-term use; however, it may be reauthorized upon review if the Member continues to meet eligibility requirements and continuation of the service is appropriate.
- One nutritional counseling session will occur **before** food is sent to Member.

6.1) WHAT **NUTRITION SENSITIVE CHRONIC OR ACUTE CONDITION DOES THE MEMBER HAVE THAT WOULD BENEFIT FROM MEDICALLY SUPPORTIVE FOOD?**

→ Select all that apply:

- Being Discharged from the Hospital or a SNF, or at High Risk of Hospitalization or Nursing Facility Placement (Expedited Referral (Post-Acute Care – 3 Business Days))
- Malnutrition with MST Scores of ≥ 3
- Diabetes (A1C ≥ 9)
- Cardiovascular Disorder
- Congestive Heart Failure (class 3 or 4) and Hospitalized x1 in the last 6 months
- Renal Failure (Dialysis or stage 4 or 5 with Hospitalization x1 in the last 6 months)
- Stroke (post discharge)
- Chronic Lung Disorders (COPD, CF, Emphysema, Interstitial Lung, or other Severe Lung Disease Post-Hospitalization)
- Human Immunodeficiency Virus (HIV) with MST Scores of ≥ 3
- Cancer Post-Hospitalization or Active Chemotherapy or During Radiation Therapy
- Gestational Diabetes While Pregnant
- Pregnancy-Induced Hypertension (PIH)
- Postop Bariatric During Pregnancy or Other High-Risk Perinatal Conditions While Pregnant
- Chronic and disabling mental/behavioral health disorder

6.2) IDENTIFY MEMBER MEAL TYPE:

→ Select the one that applies:

- Pantry and Produce Boxes
- Prepared Meals

6.3) PLEASE NOTE ANY SPECIAL DIETARY NEEDS (e.g. vegetarian, kosher, pureed food) **AND/OR ALLERGIES:**

6.4) MEMBER'S HOME ADDRESS FOR DELIVERY (if not the same as in [Section A](#)):

SECTION B: COMMUNITY SUPPORT SERVICES

6. Medically Tailored Meals/Medically Supportive Food (Page 2 of 2)

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

7. Asthma Remediation (Page 1 of 2)

Important Information – Please Read

Description: Assists Members with poorly controlled asthma to address environmental triggers in the home and avoid emergency services or hospitalization.

Key Information:

- This Community Support service has two steps:

Step 1: Members **MUST** first be referred to Asthma Preventive Services (APS).

- APS eligibility criteria: Member must have a current diagnosis of poorly controlled asthma, or on the recommendation of a licensed physician, nurse practitioner, or physician assistant.
- If eligible, an in-home environmental trigger assessment” is required to identify physical modifications to a home or supplies that would reduce the likelihood of acute asthma episodes **AND** clinic-based or home-based asthma self-management education.
- The in-home assessment **MUST** be completed within the last 12 months, assuming no change in the Member’s residence.

Step 2: After the in-home environmental trigger assessment has been completed, the Member may then request supplies and/or physical modifications as part of this service.

- Asthma remediation **supplies and physical modifications** are payable up to a total lifetime maximum of \$7,500.
- Written consent is **required** from **both** the Member and the property owner/landlord before commencement of a permanent physical adaptation or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall.
 - This does **not** apply to the provision of supplies.

7.1) IS THE MEMBER DIAGNOSED WITH ASTHMA? THE MEMBER MUST HAVE POORLY CONTROLLED ASTHMA AS DOCUMENTED BY:

→ Select the one that applies:

- A)** One ED visit or hospitalization, or two sick or urgent care visits in the past 12 months; **OR**
- B)** Asthma Control Test score of 19 or lower; **OR**
- C)** Has a documented recommendation by a licensed physician, nurse practitioner, or physician assistant

7.2) HAS THE MEMBER RECEIVED AN ASTHMA PREVENTIVE SERVICES ASSESSMENT IN THEIR CURRENT HOME WITHIN THE PAST 12 MONTHS?

→ Select the one that applies:

- A)** No, Member needs to have an in-home assessment completed
- B)** Yes → If selected, proceed with questions 7.3 and 7.4

SECTION B: COMMUNITY SUPPORT SERVICES

7. Asthma Remediation (Page 2 of 2)

COMPLETE QUESTIONS 7.3 AND 7.4 ONLY IF MEMBER HAS COMPLETED
APS ASSESSMENT WITHIN THE LAST 12 MONTHS.

7.3) WHAT IS THE MEMBER REQUESTING?

→ Select all that apply:

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) filtered vacuums
- Integrated Pest Management (IPM) services*
- De-humidifiers
- Mechanical air filters/air cleaners
- Other moisture-controlling interventions
- Minor mold removal and remediation services*
- Ventilation improvements*
- Asthma-friendly cleaning products and supplies
- Other interventions; please list below:

Requires a completed consent form to proceed

7.4) WHAT IS THE MEMBER'S HOME OWNERSHIP STATUS?

→ Select the one that applies:

- A)** Owns their home
- B)** Rents their home
- C)** Other, please specify:

COMMENTS (optional)

STOP! PLEASE READ BEFORE SUBMITTING

Complete all required fields to the best of your ability and submit this form via secure email to the appropriate region. Incomplete or outdated forms may cause processing delays. The most updated referral forms can be found on the Provider Portal.

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