KAISER PERMANENTE®

Community Supports – Referral Form
Keeping Members at the Home and Chronic Conditions

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 Community Supports referrals – referrals will be accepted from all points of care within the continuum.

What are Community Support services?

Community Supports (CS) 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.

Which Community Support services does this referral form cover?

This referral form is for the CS services aimed to Keep the Member at Home and for Chronic Conditions, which includes:

Keeping Members at Home

- Respite Services (Caregiver Respite)
- Assisted Living Facility Transitions
- Community or Home Transition Services
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)

Chronic Conditions

- Medically Tailored Meals/Medically-Supportive Food
- Asthma Remediation

Instructions

Fill out this form and all required fields to the best of your ability. Submit this form to the appropriate region via secure email. Missing information may result in additional processing delays.

- Northern California referrals REGMCDURNs-KPNC@KP.org
- Southern California referrals RegCareCoordCaseMgmt@KP.org

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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*	**Referrer Organization Name***
Referrer Email*	**Referrer Phone Number***
Referrer Relationship to Member*	

External referral by, select ONE*

☐ Network Lead Entity (NLE)

☐ ECM/CS Vendor (please indicate which NLE you are affiliated with)

☐ Full Circle Health ☐ Independent Living Systems ☐ Mom's Meals ☐ Partners in Care

☐ Managed Care Plan (MCP)

☐ Other health care provider

☐ Mental health care provider

☐ Hospital or ER care team

☐ County or other government organization

☐ Schools/Local Education Agencies (LEAs)

☐ Other community-based provider

☐ Legal aid organizations

☐ Justice involved organizations

☐ Other:

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 participating in the program(s) they are being referred to AND that you can provide supporting documentation if requested.

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SECTION A

Fields marked with an asterisk (*) are mandatory

Member Information

Member Name*

Member Date of Birth* | **Member Phone Number***

Member Mailing Address* (Street, City, State, Zip Code)

Member's Kaiser Permanente MRN* (if known) | **Member's Medi-Cal CIN** (if known)

Caregiver/Support Person Name

Caregiver/Support Person Contact (Email/Phone Number)

Current Service Usage

Is the Member currently receiving any of the following services? Check ALL that apply:

☐ **Enhanced Care Management**

Provider Name:

Provider Email/Phone Number:

☐ **Complex Case Management**

☐ **Community Health Worker**

Community Supports:

☐ Housing Transition Navigation Services
☐ Housing Deposits
☐ Housing Tenancy and Sustaining Services
☐ Day Habilitation Programs
☐ Recuperative Care (Medical Respite)
☐ Short-Term Post-Hospitalization Housing
☐ 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
☐ Sobering Centers
☐ Asthma Remediation

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SECTION B

☐ 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.
- 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:

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

OR

Other subsets include children who belong to any of the following categories. Select the ONE that applies:

☐ Previously were 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

☐ Member lives in a location where services can be provided

Comments (optional)

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SECTION B

☐ 2. Assisted Living Facility Transitions

Important Information – Please Read

- **Description:** Help to place in a sustainable assisted living facility (ALF) to avoid institutionalization.
- This CS is comprised of two components: 1) Time-Limited services and 2) Ongoing ALF services.
- **Name Change:** As of the April 2025 DHCS Policy Guide, this Community Support service was retitled to Assisted Living Facility Transitions (previously known as, Nursing Facility Transition/Diversion to Assisted Living Facilities).
- Before submitting a referral: **1)** Consider other care options (e.g. Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Caregiver Respite, etc.), and **2)** If the Member lives in Assisted Living Waiver (ALW) county, they should be placed in an ALW licensed facility.
- **Kaiser Permanente Medi-Cal Members must first be authorized for Time-Limited services, even if they are already living in an ALF**. This is to ensure that all placements are appropriate and sustainable for the Member **and** for any assessments and documentation to be obtained.
- An in-person assessment **MUST** be conducted to confirm eligibility and verify clinical status for Time-Limited services and Ongoing ALF services.
- The Member will be required to provide financial documents for Ongoing ALF services. **If approved, the Member is required to pay for room and board at the facility**.

2.1) Nursing Facility Transition: To be eligible, the Member MUST meet ALL of the following criteria. Members residing in a nursing facility who:

☐ Member has resided 60+ days in a Nursing Facility; **AND**

☐ Member is willing to live in an assisted living setting as an alternative to a Nursing Facility**; AND**

☐ Member is able to reside safely in an ALF

2.2) Nursing Facility Diversion: To be eligible, the Member MUST meet ALL of the following criteria. Members residing in the Community who:

☐ Member is interested in remaining in the community**; AND**

☐ Member is willing and able to reside safely in an ALF**; AND**

☐ Member meets the minimum criteria to receive nursing facility level of care (LOC) services and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF

2.3) Where is the Member's currently residing? Select the ONE that applies:

☐ At home

☐ In a Skilled Nursing Facility (SNF)

☐ In an ALF

☐ Other, please specify:

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SECTION B

☐ 2. Assisted Living Facility Transitions (Continued)

2.4) If the Member is currently living in an ALF, please complete the following:

Facility Name:

Facility Address:

Describe how costs are being covered:

Comments (optional)

SECTION B

☐ 3. Community or Home Transition Services

Important Information – Please Read

- **Description:** Help with non-recurring costs to move from licensed facility to private residence.
- **Name Change:** As of the April 2025 DHCS Policy Guide, this Community Support service was retitled to Community or Home Transition Services (previously known as, Community Transition Services/Nursing Facility Transition to a Home).

3.1) To be eligible, the Member MUST meet ALL of the following criteria:

☐ Member is receiving medically necessary nursing facility LOC services **AND**

☐ Has lived 60+ days in a nursing home and/or Medical Respite setting **AND**

☐ Interested in moving back to the community **AND**

☐ Able to reside safely in the community with appropriate and cost-effective supports and services

Comments (optional)

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SECTION B

☐ 4. Personal Care and Homemaker Services

Important Information – Please Read

- **Description:** Provides in-home support with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).
- If the Member does not meet eligibility and needs assistance applying for In-Home Supportive Service (IHSS), contact the NCAL/SCAL Medi-Cal care coordination team via email.

4.1) To be eligible, the Member MUST meet ONE of the following criteria. Select the ONE that applies:

☐ Member is at risk of hospitalization or institutionalization in a nursing facility **OR**

☐ Member has functional deficits and no other adequate support system

4.2) To be eligible, the Member MUST meet ONE of the following criteria. Select the ONE that applies:

☐ The Member has applied for IHSS and awaiting determination **OR**

☐ The Member was approved for IHSS and is applying for additional hours

Comments (optional)

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SECTION B

☐ 5. Environmental Accessibility Adaptations (Home Modifications)

Important Information – Please Read

- **Description:** Physical home adaptations for member's health, welfare, safety, and independence.
- 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 to the home or equipment that is physically installed in the home.

5.1) Is the Member at risk of being institutionalized in a nursing facility?

☐ Yes ☐ No (If no, do not continue; Member is not eligible)

5.2) If yes, what is the Member is 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) If yes, what is the Member's home ownership status? Select the ONE that applies:

☐ Owns their home

☐ Rents their home

☐ Other, please specify:

Comments (optional)

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SECTION B

☐ 6. Medically Tailored Meals/Medically Supportive Food

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.
- 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.

6.1) What nutrition sensitive chronic or acute condition does the Member have that would benefit from medically supportive food?

☐ 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 Cores 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

☐ Other, please specify:

6.2) Identify meal type:

☐ Pantry and Produce

☐ Prepared food

6.3) Please note any special requests and/or allergies:

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SECTION B

☐ 6. Medically Tailored Meals/Medically Supportive Food (Continued)

6.4) Member's Home Address for delivery (if not the same as in Section A)

Comments (optional)

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SECTION B

☐ 7. Asthma Remediation

Important Information – Please Read

- **Description:** Assists Members with poorly controlled asthma to address environmental triggers in the home and avoid emergency services or hospitalization.
- Members with poorly controlled asthma (as determined by an emergency department (ED) visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, ED visits, or other high-cost services.
- Asthma remediations are payable up to a total lifetime maximum of $7,500.
- If eligible, a home visit is required to identify asthma triggers and appropriate modifications.
- 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) Member with poorly controlled asthma must meet ONE of the following eligibility criteria. Select the ONE that applies:

☐ Emergency Department visit, or hospitalization or two sick or urgent care visits in the past 12 months; **OR**

☐ Asthma Control Test score of 19 or lower; **OR**

☐ Have a recommendation from a licensed health care provider that the service will likely avoid asthma-related hospitalizations, emergency department visits, and other high-cost services.

7.2) The following are examples of approved asthma trigger remediation and modifications. Select ALL remediations/modifications that would best support the Member:

☐ Allergen-impermeable mattress and pillow dustcovers

☐ High-efficiency particulate air (HEPA) filtered vacuums

☐ Integrated Pest Management (IPM) services

☐ De-humidifiers

☐ Air filters

☐ Other moisture-controlling interventions

☐ Minor mold removal and remediation services

☐ Ventilation improvements

☐ Asthma-friendly cleaning products and supplies

☐ Other intervention:

Comments (optional)

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STOP!
PLEASE BE SURE TO:

Fill out this form and all required fields to the best of your ability. Submit this form to the appropriate region via secure email. Missing information may result in additional processing delays.

- Northern California referrals REGMCDURNs-KPNC@KP.org
- Southern California referrals RegCareCoordCaseMgmt@KP.org