HealthPlan OF SAN MATEO

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

HPSM Community Supports Referral Form

Select only one service per referral form. Member must meet the following basic qualifications to be eligible for Community Supports:

- Active HPSM Medi-Cal or CareAdvantage
- Engaged with a Care Manager
- Willing to receive Community Supports

☐ By submitting this form, I attest that:

- The member meets the eligibility criteria for the Community Supports service selected.
- The member and/or their legal guardian/conservator has given consent to request Community Supports.
- I, the referent, attest to the best of my knowledge that the information in the form is correct.

Asterisk (*) indicates required information.

Type of Referral:* ◯ Routine ◯ Urgent (service is medically needed within three (3) business days of submission)

Date of Referral:* _____

MEMBER INFORMATION

Last Name:* _____ **First Name:*** _____

Date of Birth:* _____ **Language:** ◯ Speaks English ◯ Does not speak English

HPSM Member ID #:* _____ **Preferred Language:** _____

Medi-Cal Client Index Number (CIN): _____ ◯ Medi-Cal ◯ CareAdvantage

☐ **Member has no fixed residential address** (If available, please enter a frequently visited location below.)

Member's Address:* _____

Phone:* _____ **Email:** _____

Is member enrolled in Enhanced Care Management (ECM)? ◯ Yes ◯ No

If yes, name of ECM provider: _____

Visit www.hpsm.org/ecm-provider-list for a current list of ECM providers.

MEMBER INFORMATION continued

Description of member's presenting issues resulting in need for Community Supports:

LEGAL GUARDIAN/CONSERVATOR (required if applicable)

Last Name: _____ **First Name:** _____

Phone: _____

REFERENT INFORMATION (entity making the referral)

Last Name:* _____ **First Name:*** _____

Agency/Org/Facility Name:* _____

NPI # (required if applicable): _____ **Phone:*** _____

Email:* _____ **Fax (required if applicable):** _____

Relationship to Member:* ☐ ECM Provider ☐ Care Manager ☐ Primary Care Provider

☐ Other: _____

☐ **Referring entity attests that they initiated the referral to the Rendering Provider***

RENDERING PROVIDER INFORMATION

Last Name:* _____ **First Name:*** _____

Agency/Org/Facility Name:* _____

NPI # (required if applicable): _____ **Phone:*** _____

Email:* _____ **Fax (required if applicable):** _____

COMMUNITY SUPPORTS SERVICES REQUESTED

For the Community Support option you select below, please check all criteria that apply.

Please note only one Community Support can be selected per form.

Estimated duration of service: _____

☐ 1. Transitional Rent

☐ Clinical Risk Factor Requirement (check HPSM Cal-AIM for qualifying clinical risk factors)

and

☐ Social Risk Factor Requirement: Experiencing or at risk of homelessness

and ONE of the following:

☐ Transitional Rent Population Requirement (check HPSM Cal-AIM for qualifying transitional rent populations)

or

☐ Experiencing unsheltered homelessness

or

☐ Eligible for Full-Service Partnership (FSP)

☐ 2. Housing Transition and Navigation Services

☐ Social Risk Factor Requirement: Experiencing or at risk of homelessness

and

☐ Clinical Risk Factor Requirement (check HPSM Cal-AIM for qualifying clinical risk factors)

or

☐ Prioritized for permanent supportive housing or rental subsidy resource through San Mateo CES or similar County system/resource.

☐ 3. Housing Deposit

☐ Social Risk Factor Requirement: Experiencing or at risk of homelessness

and

☐ Clinical Risk Factor Requirement (check HPSM Cal-AIM for qualifying clinical risk factors)

or

☐ Prioritized for permanent supportive housing or rental subsidy resource through San Mateo CES or similar County system/resource.

☐ 4. Housing Tenancy and Sustaining Services – Available a single duration in a lifetime.

☐ Social Risk Factor Requirement: Experiencing or at risk of homelessness

and

☐ Clinical Risk Factor Requirement (check HPSM Cal-AIM for qualifying clinical risk factors)

or

☐ Prioritized for permanent supportive housing or rental subsidy resource through San Mateo CES or similar County system/resource.

☐ 5. Environmental Accessibility Adaptations (Home Modifications)

May not receive duplicative support from state, local or federal program (e.g., HCBA Waiver); consider other funding before Community Supports.

- ☐ Received PT/OT evaluation supporting medical necessity.
- ☐ Has PCP or other health professional Rx/order for medically necessary equipment or service.

☐ 6. Assisted Living Facility (ALF) Transitions

Formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFE). May not receive duplicative support from state, local or federal program (e.g., ALW); consider the above funding before Community Support.

Skilled Nursing Facility (SNF) transition:

- ☐ Residing in SNF for 60+ days.

and

- ☐ Willing and able to reside safely in an assisted living facility/RCFE in lieu of SNF with appropriate supports in place.

SNF diversion:

- ☐ Desires to remain in the community.

and

- ☐ Willing and able to reside safely in an ALF.

and

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

☐ 7. Community or Home Transition Services

Formerly known as Community Transition Services / Nursing Facility Transition to a home. May not receive duplicative support from state, local or federal funding (e.g., ALW Waiver); consider the above funding before Community Support.

- ☐ Is currently receiving medically necessary nursing facility LOC services and in lieu of remaining in the nursing facility or recuperative care setting is choosing to transition home and continue to receive medically necessary nursing facility LOC services.

and

- ☐ Has lived 60+ days in a nursing home and/or recuperative care setting and is interested in moving back to the community.

and

- ☐ Are able to reside safely in the community with appropriate and cost-effective supports and services.

8. Respite Services

- [ ] Lives in the community and compromised in their activities of daily living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support and who require caregiver relief to avoid institutional placement.

9. Personal Care and Homemaker Services

This service cannot be utilized in lieu of referring to the In-Home Supportive Services (IHSS) program. Member must be referred to IHSS when they meet referral criteria.

- [ ] Approved for IHSS but needs additional hours. IHSS benefits are exhausted.
- [ ] Currently in IHSS waiting period. Includes services prior to and through the IHSS application date for an IHSS-referred member during IHSS waiting period.
- [ ] If not eligible for IHSS, to help avoid a short-term SNF stay (not to exceed 60 days).
- [ ] Has functional deficits and no other adequate support system.

10. Asthma Remediation

To complete authorization, please also submit a current licensed health care provider's order specifying the requested remediation(s) for the member; a brief written evaluation specific to the member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost effective"; and that a home visit has been conducted to determine the suitability of any requested remediation(s) for the member.

- [ ] Individuals with poorly controlled asthma (as determined by an emergency department 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 healthcare provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits or other high-cost services.

11. Medically Tailored Meals (MTM)

MTM is covered up to two meals per day for 12 weeks. Not intended to solely address food insecurity.

- [ ] Individuals who have chronic or other serious health conditions that are nutrition sensitive.

  Condition that is nutrition sensitive: _____

- [ ] Nutritional Assessment completion date (completed by CS Meals Provider): _____

- [ ] End date of Nutritional Counseling Services (completed by CS Meals Provider): _____

Medically Tailored Meals (MTM) continued

Select all allergens that apply:

☐ Milk ☐ Egg ☐ Wheat
☐ Fish ☐ Shellfish ☐ Peanuts
☐ Soy ☐ Tree nuts ☐ Other: _____

Desired meal type	Standard	Secondary (optional)
General wellness – follows Dietary Guidelines for Americans	☐	☐
Lower sodium (sodium <600 mg)	☐	☐
Heart-friendly (sodium <800 mg, saturated fat <10%, total fat <30%)	☐	☐
Diabetes-friendly (carbs <65%/entrée)	☐	☐
Renal-friendly (sodium <700 mg, potassium <833 mg, phosphorus <300 mg)	☐	☐
Gluten-free (tested less than 20 ppm, not a dedicated kitchen)	☐	☐
Protein+ (calories >600, protein >25 g)	☐	☐
Vegetarian (includes dairy, eggs, plant protein, nuts, beans - vegan not available)	☐	☐
Puréed (for dysphagia patients and those with difficulty swallowing)	☐	☐
Shelf-stable meals (not medically-tailored)	☐	☐

☐ **Special delivery instructions (please describe):**

SUBMISSION INFORMATION

Please refer to the "Refer a Member for Community Supports" section of the HPSM Community Supports provider webpage for specific instructions on how to submit this form to the chosen Rendering Provider for the Community Support service indicated. Please check Rendering Provider capacity before submitting this referral form.

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