HealthPlan OF SAN MATEO
Healthy is for everyone

UpwardHealth®

HomeAdvantage Non-Cohort Member Referral

This form can be used to refer a "non-cohort" HPSM member for time limited HomeAdvantage services provided by Upward Health. This referral is appropriate for those whom HPSM and Upward Health identify as a member who can benefit from receiving in-home medical care for a specific time frame to support their health needs and goals of care.

Fax this referral form to HPSM Care Coordination: **650-829-2047 (**For facility discharge support, include FocusCare Referral Checklist form)

Information about patient

Name: _____ DOB: _____ Age: _____

Home address: _____

Phone #: _____ Phone # per patient (if different): _____

HPSM member ID #: _____ Effective date: _____

HPSM Case Manager (if known): _____ Line of business: _____

Patient is discharging from a facility: ☐ Yes ☐ No

If yes, Facility Name: _____

Address: _____

Information about referring party

Date of Referral: _____

First name: _____ Last name: _____

Agency/Organization/Facility: _____

Relationship to patient: _____

Phone #: _____ Email address: _____

Consent for referral obtained from: ☐ Patient ☐ AOR (consent must be obtained prior to submitting referral)

Diagnosis

- ☐ Atrial Fibrillation
- ☐ Behavioral Health
- ☐ Cancer
- ☐ Cerebral Vascular Disease
- ☐ Chronic Kidney Disease
- ☐ Coronary Heart Disease/MI
- ☐ Diabetes
- ☐ Disabling Condition
- ☐ End State Renal Disease
- ☐ Fluid and Electrolyte Disorders
- ☐ Frailty: Pressure Ulcers w/Necrosis (Stg 4)
- ☐ Frailty: Protein-Calorie Malnutrition
- ☐ Heart Failure
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ Severe Chronic Liver Disease
- ☐ Substance Abuse Disorder
- ☐ Vascular Disease
- ☐ Other: _____

Other factors

- ☐ Developmental disability
- ☐ Cognition: ☐ Mild cognitive impairment ☐ Dementia
- ☐ Hospice
- ☐ Homeless: ☐ Marginally housed ☐ At risk of losing current housing
- ☐ Palliative care
- ☐ Mental illness: ☐ DSM-V diagnoses: _____
- ☐ Substance use (describe): _____

3. Does the patient have decision-making capacity?

☐ Yes ☐ No (please provide information below)

If no, name of agent for decision-making: _____

If an AOR is on file, please identify: _____

4. PCP information

Name: _____

Phone #: _____ Email address: _____

If patient sees a physician other than the assigned PCP for primary care, please enter the physician's name:

_____

Date of last appointment with the PCP/other physician? _____

What are the barriers to getting to the appointments? _____

Does this PCP have telehealth capabilities? ☐ Yes ☐ No

Is PCP aware that member is being referred to Upward Health? ☐ Yes ☐ No

5. Current services

Please list the services the patient is currently receiving, including Home and Community Based Services (HCBS):

6. Upward Health

Patient is in need of facility discharge support ☐ Yes ☐ No

If yes, complete *FocusCare Referral Checklist Form

Describe why Upward Health needs to see this patient (attach additional supporting documentation, if appropriate):

Knowing the duration of Upward Health's involvement is limited, how long do you expect the patient will need their support?

☐ 1 month ☐ 2 months ☐ 3 months ☐ Longer (explain): _____

Identify the care goals necessitating this referral:

*FocusCare Referral Checklist Form must be included with referral form if requesting facility discharge support.

HPSM ADMINISTRATIVE STAFF ONLY

Reviewed by: Medical Director Date of review: _____ Decision: ☐ Approved ☐ Denied

Integrated Service Manager: ☐ Emerging risk ☐ High risk ☐ Early intervention

Email referrals to **hpsmreferrals@upwardhealth.com**