

HPSM Community Supports Request Information Form

This form must be submitted with Prior Authorization Request Form. *Note: Member must meet the basic qualifications (active HPSM Medi-Cal or CareAdvantage, engaged with a Care Manager and willing to receive Community Support) to be eligible for Community Supports.*

Step 1: Fill out all applicable information then proceed to Step 2.

MEMBER'S INFORMATION		
Member's Last Name:	Member's First Name:	
Date of Birth:	Language:	
Phone:	<input type="checkbox"/> Member speaks English <input type="checkbox"/> Member does not speak English	
Email:	Preferred Language: _____	
Home Address:	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> CareAdvantage	
HPSM ID #:	<input type="checkbox"/> Meets basic qualifications as listed above	
REFERENT INFORMATION		
First Name:	Agency/Org/Facility Name:	
Last Name:	Relationship to Member:	
NPI #:	<input type="checkbox"/> ECM Provider	
Phone:	<input type="checkbox"/> Care Manager	
Email:	<input type="checkbox"/> Primary Care Provider	
Fax:	Other provider, please describe: _____	
<input type="checkbox"/> Member or authorized support person provided consent to request for Community Supports	Is member enrolled in ECM? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ECM provider: _____ <i>List of our ECM providers: www.hpsm.org/provider/calaim</i>	
Please provide a brief description regarding member's presenting issues to result in need for Community Supports:		
REFERENT INFORMATION		
If requesting Medically Tailored Meals only, please complete this section selecting all allergens that apply: <input type="checkbox"/> Milk <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Tree nuts <input type="checkbox"/> Egg <input type="checkbox"/> Peanuts <input type="checkbox"/> Soy wheat <input type="checkbox"/> Other: _____		
Desired Meal Type:	Primary	Secondary (optional)
General Wellness – General Default Vegetarian (includes dairy, eggs, plant protein, nuts and beans - Vegan not available)	<input type="checkbox"/>	<input type="checkbox"/>
Lower Sodium (sodium 600, protein >25g)	<input type="checkbox"/>	<input type="checkbox"/>
Heart-Friendly (sodium <10%)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes-Friendly (carbs <65%/entrée, 100g/meal)	<input type="checkbox"/>	<input type="checkbox"/>
Renal-Friendly (sodium <700mg, potassium <833 mg, phosphorus <300mg)	<input type="checkbox"/>	<input type="checkbox"/>
Gluten-Free (tested less than 20ppm, not a dedicated kitchen)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer Support (calories >600, protein >25g)	<input type="checkbox"/>	<input type="checkbox"/>
Vegetarian (includes dairy, eggs, plant protein, nuts, beans - vegan not available)	<input type="checkbox"/>	<input type="checkbox"/>
Puréed (for dysphagia patients and those with difficulty swallowing)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Special delivery instructions, please describe: _____		

Step 2: Select the Community Supports service(s) requested and check all member eligibility criteria below each service selected that apply then proceed to Step 3. See webpage for description of services: www.hpsm.org/provider/calaim

MEMBER COMMUNITY SUPPORTS SERVICE CRITERIA INFORMATION	
Program Name	Eligibility Criteria (select all that apply):
<input type="checkbox"/> Housing Transition Navigation Services	<input type="checkbox"/> Homeless/at risk of homelessness. <input type="checkbox"/> Prioritized for permanent supportive housing or rental subsidy through San Mateo County system/resource. <input type="checkbox"/> Receiving Enhanced Care Management.
<input type="checkbox"/> Housing Deposit <i>*Member must be receiving Housing Transition Navigation Services. Available once in a lifetime.</i>	<input type="checkbox"/> Received Housing Transition Navigation Services. <input type="checkbox"/> Prioritized for permanent supportive housing or rental subsidy through San Mateo County or other resource. <input type="checkbox"/> Homeless/at risk of homelessness. <input type="checkbox"/> Receiving Enhanced Care Management.
<input type="checkbox"/> Housing Tenancy and Sustaining Services <i>*Available a single duration in a lifetime.</i>	<input type="checkbox"/> Received Housing Transitions Navigation Services. <input type="checkbox"/> Prioritized for permanent supportive housing or rental subsidy through San Mateo County system/resource. <input type="checkbox"/> Receiving Enhanced Care Management.
<input type="checkbox"/> Environmental Accessibility Adaptations (Home Modifications) <i>* May not receive duplicative support from state, local or federal program (e.g., HCBA Waiver), consider other funding before Community Supports.</i>	<input type="checkbox"/> Received PT/OT evaluation supporting medical necessity. <input type="checkbox"/> Has PCP or other health professional Rx/order for medically necessary equipment or service.
<input type="checkbox"/> Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFE) <i>*May not receive duplicative support from state, local or federal program (e.g., ALW Waiver), consider the above funding before Community Support.</i>	SNF Transition: <input type="checkbox"/> Residing in SNF for 60+ days. <input type="checkbox"/> Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place. SNF Diversion: <input type="checkbox"/> Desires to remain in the community. <input type="checkbox"/> Meets minimum criteria for SNF level of care. <input type="checkbox"/> Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place.
<input type="checkbox"/> Community Transition Services/ Nursing Facility Transition to a home <i>*May not receive duplicative support from state, local or federal funding (e.g., ALW Waiver), consider the above funding before Community Support.</i>	<input type="checkbox"/> Residing in SNF or medical respite setting for 60+ days. <input type="checkbox"/> Desires to live in the community. <input type="checkbox"/> Willing and able to safely reside in community (home) setting with appropriate supports in place.
<input type="checkbox"/> Medically Tailored Meals (MTM) <i>*MTM is covered up to 2 meals per day for 12 weeks. Not intended to solely address food insecurity.</i>	<input type="checkbox"/> Has chronic conditions and/or disabling mental or behavioral health disorder. <input type="checkbox"/> Hospital or SNF discharge in the last 60 days, or planned for discharge. <input type="checkbox"/> Receiving Enhanced Care Management or has extensive care coordination needs.

☐ By checking this box, you attest that member meets the eligibility criteria for the Community Supports service(s) selected.

Step 3: Attach this completed form to the Prior Authorization Request Form along with any supporting clinical documentation and fax to HPSM's Utilization Management Team. Fax number: 650-829-2079.