HealthPlan OF SAN MATEO
Healthy is for everyone

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

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:	☐ Member speaks English ☐ Member does not speak English
Email:	Preferred Language: _____
Home Address:	☐ Medi-Cal ☐ CareAdvantage
HPSM ID #:	☐ Meets basic qualifications as listed above

REFERENT INFORMATION	
First Name:	Agency/Org/Facility Name:
Last Name:	Relationship to Member:
NPI #:	☐ ECM Provider
Phone:	☐ Care Manager
Email:	☐ Primary Care Provider
Fax:	Other provider, please describe: _____
☐ Member or authorized support person provided consent to request for Community Supports	Is member enrolled in ECM? ☐ Yes ☐ No If yes, ECM provider: _____ *List of our ECM providers: www.hpsm.org/provider/calaim*
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:

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

Desired Meal Type:	**Primary**	**Secondary (optional)**
General Wellness – General Default Vegetarian (includes dairy, eggs, plant protein, nuts and beans - Vegan not available)	☐	☐
Lower Sodium (sodium 600, protein >25g)	☐	☐
Heart-Friendly (sodium <10%)	☐	☐
Diabetes-Friendly (carbs <65%/entrée, 100g/meal)	☐	☐
Renal-Friendly (sodium <700mg, potassium <833 mg, phosphorus <300mg)	☐	☐
Gluten-Free (tested less than 20ppm, not a dedicated kitchen)	☐	☐
Protein+ (calories >600, protein >25g)	☐	☐
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: _____

HealthPlan OF SAN MATEO
Healthy is for everyone

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

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):**
☐ **Housing Transition Navigation Services**	☐ Homeless/at risk of homelessness. ☐ Prioritized for permanent supportive housing or rental subsidy through San Mateo County system/resource. ☐ Receiving Enhanced Care Management.
☐ **Housing Deposit** **Member must be receiving Housing Transition Navigation Services. Available once in a lifetime.*	☐ Received Housing Transition Navigation Services. ☐ Prioritized for permanent supportive housing or rental subsidy through San Mateo County or other resource. ☐ Homeless/at risk of homelessness. ☐ Receiving Enhanced Care Management.
☐ **Housing Tenancy and Sustaining Services** **Available a single duration in a lifetime.*	☐ Received Housing Transitions Navigation Services. ☐ Prioritized for permanent supportive housing or rental subsidy through San Mateo. County system/resource. ☐ Receiving Enhanced Care Management.
☐ **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.
☐ **Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFE)** **May not receive duplicative support from state, local or federal program (e.g., ALW Waiver), consider the above funding before Community Support.*	**SNF Transition:** ☐ Residing in SNF for 60+ days. ☐ 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. ☐ Meets minimum criteria for SNF level of care. ☐ Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place.
☐ **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.*	☐ Residing in SNF or medical respite setting for 60+ days. ☐ Desires to live in the community. ☐ Willing and able to safely reside in community (home) setting with appropriate supports in place.
☐ **Medically Tailored Meals (MTM)** **MTM is covered up to 2 meals per day for 12 weeks. Not intended to solely address food insecurity.*	☐ Has chronic conditions and/or disabling mental or behavioral health disorder. ☐ Hospital or SNF discharge in the last 60 days, or planned for discharge. ☐ Receiving Enhanced Care Management or has extensive care coordination needs.

More Community Supports on the next page >>>

MEMBER COMMUNITY SUPPORTS SERVICE CRITERIA INFORMATION	
Program Name	**Eligibility Criteria (select all that apply):**
☐ **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.
☐ **Personal Care and Homemaker Services** **This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.*	☐ At risk for hospitalization, or institutionalization in a nursing facility. ☐ Has functional deficits and no other adequate support system. ☐ Approved for In-Home Supportive Services.
☐ **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 health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

☐ 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.