KAISER PERMANENTE

Enhanced Care Management and Community Supports Referral Form

Kaiser Permanente accepts referrals for Medi-Cal members with their coverage assigned to KP that are presumed to be eligible for a Community Supports service or Enhanced Care Management. If a member is eligible, KP will issue an authorization to a supplier in our network of contracted vendors to provide the service.

Enhanced Care Management is available in all KP's service areas. The benefit is limited to specific Populations of Focus defined by the Department of Healthcare Services and provides intensive care management to members with complex health and/or social needs.

Community Supports are non-medical services provided as cost-effective alternatives (e.g., housing navigation, asthma remediation) to traditional medical services and settings. Community Supports availability varies by County.

Send this completed form to RegCareCoordCaseMgmt@KP.org to submit a referral. *Note: Referrals from KP staff should be submitted via KP HealthConnect.*

Referral Source Information

Date of Referral:	Referring Individual Name:	Referring Organization Name:
Referrer Email Address:	Referrer Phone Number:	Referrer Fax Number:
Relationship of referrer to member? ☐ Self-referral ☐ Friend/family member ☐ Other:_____		
Is this a new referral or extension? ☐ New Referral ☐ Extension		

Member Information

Name:	Phone Number:	Medi-Cal CIN # (if known):
Date of Birth:	Preferred Language:	Is member aware of referral being made on their behalf? ☐YES ☐NO ☐DON'T KNOW

Services Requested in this Referral (includes available services as of 1/1/23)

Mark the services being requested as part of this referral with an "X."

Service	Inland Empire	Kern	LA	Orange	San Diego	Ventura
Enhanced Care Management (pg. 2 required)						
Asthma Remediation (pg. 3 required)			NA			
Community Transition Services from Nursing Facility Transition to a Home (pg. 4 required)		NA				
Day Habilitation (pg. 5 required)	NA					NA
Environmental Accessibility Adaptations (Home Modifications) (pg. 6 required)		NA				
Housing Transition/Navigation (pg. 7 required)						
Housing Deposits (pg. 8 required)						
Housing Tenancy & Sustaining (pg. 7 required)						
Meals/Medically Tailored Meals (pg. 9 required)						
Nursing Facility Transition/Diversion to Assisted Living Facilities (pg. 10 required)		NA				
Personal Care and Homemaker Services (pg. 11 required)	NA					
Recuperative Care (medical respite) (pg.12 required)						
Respite services (caregiver respite)	NA					
Short-term post hospital housing (pg. 12 required)			NA			

Complex Physical, Behavioral, and Developmental Conditions (select all that apply):		
Physical Health		
☐Asthma	☐Dementia requiring assistance with IADLs	☐ Pregnancy
☐Chronic Kidney Disease	☐Diabetes (Insulin-dependent) poorly controlled	☐ Traumatic Brain Injury (TBI)
☐Chronic Liver Disease	☐ Hepatitis-C	☐ Other, specify:
☐Chronic Obstructive Pulmonary Disease (COPD)	☐ History of stroke or heart attack	
☐Congestive Heart Failure (CHF)	☐ HIV	
☐Coronary Artery Disease	☐ Hypertension (poorly controlled)	
Behavioral Health		
☐Bipolar disorder	☐Psychotic disorders, including schizophrenia	☐Other, please note:
☐Major Depressive Disorder	☐Substance Use Disorder, please specify:	
Developmental		
☐Intellectual/Developmental Disability	☐Other, please note:	

Eligibility Criteria for each Population of Focus (select all that apply):

☐ **For an Individual/Family Experiencing Homelessness or At-Risk of Homelessness:**
☐ Confirm member has at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes *AND/OR* decreased utilization of high-cost services. **Please explain:**
☐ **For an Adult High Utilizer:**
☐ 5 or more emergency room visits in the last 6 months AND/OR ☐ 3 or more unplanned hospital admissions in the last 6 months AND/OR ☐ 3 or more avoidable short-term skilled nursing facility stays in the last 6 months
☐ **For an Adult with Serious Mental Illness or Substance Use Disorder**:
☐ Meets criteria for participation in or is obtaining services through the County Specialty Mental Health (SMH) System AND/OR the Drug Medi-Cal Organized Delivery System (DMC-ODS) ☐ Actively experiencing one complex social factor influencing their health **Please explain:** ☐ Meets one or more of the following criteria: 1. High risk for institutionalization, overdose and/or suicide 2. Use crisis services, ERs, urgent care or inpatient stays as the sole source of care 3. 2+ ED visits or 2+ hospitalizations due to SMI or SUD in the past 12 months 4. Pregnant or post-partum (12 months from delivery)
☐ **For an individual who is transitioning from incarceration or transitioned from incarceration within the past 12 months**

Asthma Remediation

Complete page if this Community Supports is marked with an "X" on page 1.

Eligibility Criteria:

Member must meet at least **one** of the following criteria for poorly controlled asthma (select all that apply):
☐ Member had an emergency department visit or hospitalization due to asthma-related complications, or ☐ Member had two sick or urgent care visits in the past 12 months due to asthma-related complications, or ☐ Member scored 19 or lower on the Asthma Control Test. Please attach scores **or** fill out below.
☐ Member is not receiving duplicative support from another State, local, or federally funded program.
☐ Member has consented to Asthma Remediation referral and acknowledges once in a lifetime benefit.

Asthma Control Test (link):

Directions: Please answer the questions below and tally the score associated with the answer in the boxes on the right.					**Score**
In the past **4 weeks**, how much of the time did the member's asthma keep them from getting as much done at work, school, or at home?					
☐All the time (1)	☐Most of the time (2)	☐Some of the time (3)	☐A little of the time (4)	☐None of the time (5)	
During the past **4 weeks**, how often has the member had shortness of breath?					
☐More than once a day (1)	☐Once a day (2)	☐3-6 times a week (3)	☐Once or twice a week (4)	☐Not at all (5)	
During the past **4 weeks**, how often did the member's asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake them up at night or earlier than usual in the morning?					
☐4 or more nights a week (1)	☐2 or 3 nights a week (2)	☐Once a week (3)	☐Once or twice (4)	☐Not at all (5)	
During the past **4 weeks**, how often has the member used their rescue inhaler or nebulizer medication (such as albuterol)?					
☐3 or more times per day (1)	☐1 or 2 times per day (2)	☐2 or 3 times per week (3)	☐Once a week or less (4)	☐Not at all (5)	
How would the member rate their **asthma** control during the **past 4 weeks**?					
☐Not controlled at all (1)	☐Poorly controlled (2)	☐Somewhat controlled (3)	☐Well controlled (4)	☐Completely controlled (5)	
				Total	

KAISER PERMANENTE

Community Transition Services Nursing Facility Transition to a Home

Complete page if this Community Supports is marked with an "X" on page 1.

Eligibility Criteria (select one):

Currently receiving medically necessary nursing facility level of care services and, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically nursing facility level of care services	YES ☐	NO ☐
Has lived 60+ days in a nursing home and/or medical respite setting	YES ☐ Admission Date:	NO ☐
Interested in moving back to the community	YES ☐	NO ☐
Able to reside safely in the community with appropriate and cost-effective supports and services	YES ☐	NO ☐

Please indicate which, if any, of the following services are needed to establish a basic household:

1.	Security Deposit	YES ☐ Amount:	NO ☐
2.	Set-up fees for utilities	YES ☐ Amount:	NO ☐
3.	First month coverage of utilities	YES ☐ Amount:	NO ☐
4.	Pest eradication	YES ☐ Amount:	NO ☐
5.	One-time cleaning prior to occupancy	YES ☐ Amount:	NO ☐
6.	Air conditioner and/or heater	YES ☐ Amount:	NO ☐
7.	Medically necessary services (i.e., hospital bed, Hoyer life)	YES ☐ Amount: Specify services:	NO ☐

Please complete only if #s 6 and/or 7 were selected "yes" above

Please provide additional details including how and why the equipment or service will meet the needs of the member:			
Home Visit Completed?	☐ Yes ☐ No	Date of Visit:	
Type of Home:	☐ Single, one-unit building detached from any other building ☐ One-unit building attached to one or more buildings ☐ Building with two or more apartments ☐ Manufactured/Mobile Home		
Number of Stories:			
The home is:	☐ Owned by the member or caregiver ☐ Rented/Leased by the member or caregiver* ☐ Occupied by the member or caregiver (without payment of rent)*		
*NOTE: If member does not own the home, member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g. grab bars, chair lifts, etc.)			

Day Habilitation

Complete page if this Community Supports is marked with an "X" on page 1.

Which option best reflects the member's current living situation (select one):

- ☐ Experiencing homelessness
- ☐ Recently exited homelessness and entered housing in the last 24 months
- ☐ At risk of homelessness or institutionalization
- ☐ None of the above

Could member's housing stability be improved through participation in a day habilitation program? (Programs are designed to assist members to obtain and retain self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment).

- ☐ Yes
- ☐ No/Unsure

KAISER PERMANENTE

Environmental Accessibility Adaptations (Home Modifications)

Complete page if this Community Supports is marked with an "X" on page 1.

Is the member at risk for institutionalization in a nursing facility? ☐ Yes ☐ No

Is the member receiving duplicative support from another State, local, or federally funded program? ☐ Yes ☐ No

Building Information			
Home Visit Completed?	☐ Yes ☐ No	Date of Visit (must be within the past 90 days):	
Type of Home:	☐ Single, one-unit building detached from any other building ☐ One-unit building attached to one or more buildings ☐ Building with two or more apartments ☐ Manufactured/Mobile Home		
Number of Stories:			
The home is:	☐ Owned by the member or caregiver ☐ Rented by the member or caregiver* ☐ Leased by the member or caregiver* ☐ Occupied by the member or caregiver (without payment of rent)*		
*NOTE: If member does not own the home, member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g. grab bars, chair lifts, etc.)			

Environmental Accessibility Adaptations (Home Modifications)	
This request is for: (select all that apply)	☐ Equipment ☐ Home Modification ☐ Personal Emergency Response System (PERS)
Please provide additional details including how and why the equipment or service will meet the needs of the member:	

Medical Necessity			
Has the member received a physical or occupational therapy evaluation to assess the medical necessity of the equipment and/or services requested above?			☐ Yes ☐ No
If yes, please provide the name of the provider and date of evaluation.			
Name of Provider		Date of Evaluation:	

KAISER PERMANENTE®

Housing Transition Navigation Services or Housing Tenancy Sustaining Services

Complete page if either of these Community Supports are marked with an "X" on page 1.

Select the housing status that best describes the member (select one):

☐ At risk of homelessness	☐ Homeless	☐ Chronically Homeless

Member's current living location (select one):

☐Interim Housing ☐Permanent Supportive Housing ☐Shelter ☐Vehicle ☐Street ☐Other: _____ (please specify)

Does member meet at least one of the following criteria related to their housing status (select all that apply):

- ☐ Received the Housing Transition Navigation Community Supports and was recently placed in permanent housing
- ☐ Prioritized for a permanent supportive housing unit or rental subsidy resource through the CES
- ☐ Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, etc.
- ☐ Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals)
- ☐ Exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
- ☐ Will imminently lose their primary nighttime residence within 14 days and lacks the resources to obtain other permanent housing
- ☐ Unaccompanied youth under 25 years of age, or families with children and youth with extenuating circumstances that lead to housing instability
- ☐ Fleeing domestic violence and lacks resource to obtain other permanent housing
- ☐ At risk of homelessness which may include living in the home of another because of economic hardship, has moved because of economic reasons two or more times in the last 60 days, living in a hotel/motel not paid by a charitable org or other public funds, etc. Lacks the resources or support network to stabilize housing
- ☐ Don't know/unsure

Does member meet any of the following (select all that apply):

- ☐ Has one or more serious chronic conditions OR a serious mental illness
- ☐ Is at risk of institutionalization or overdose or requires residential services because of a substance use disorder
- ☐ Is receiving Enhanced Care Management
- ☐ Is a transition-aged youth with significant barriers to housing instability (e.g. history of foster care or involvement with the criminal justice system)
- ☐ Don't know/unsure

To the best of your knowledge, has member previously received either Community Support (select one):

Housing Transition Navigation ☐YES ☐NO ☐DON'T KNOW	Housing Tenancy & Sustaining ☐YES ☐NO ☐DON'T KNOW
If yes, when and with which provider?	

Additional information on member's housing status and housing needs: _____

KAISER PERMANENTE®

CalAIM Community Supports (CS) Housing Deposits Referral Request Form

Please email completed form to RegCareCoordCaseMgmt@KP.org.

Include the below required documentation in your request:
For all requests: 1) Assessment 2) Housing Plan (including last encounter with member and sustainability plan)
For security deposit requests: 1) Lease Agreement, 2) Amount of Security Deposit

Please note KP may request additional documentation, including Unit Inspection report, Utility Bill, Invoices/Receipts, Medi-Cal DME Denial Letter, etc. These documents need to be made available to KP upon request.

Request Date: _____
Requesting Agency: _____ **Name of Requestor:** _____
Email of Requestor: _____ **KP Case Manager:** _____

Member Information			
Member Last Name:		Member First Name:	
DOB:		Medi-Cal CIN:	
KP Medical Record Number (MRN):		Is member currently receiving Housing Transition Navigation Services?	
Mailing address of permanent housing unit:		Date member is moving into permanent housing:	
Has member previously received Community Supports (CS) Housing Deposits (with KP or other health plan)?		If yes, please indicate when member previously received Housing Deposits and provide a description of how conditions have changed:	

List of Requested Services:

Please Note: KP does not cover furniture and household goods under housing deposits.

#	*Service:*	*Description:*	*Estimated Cost:*	*Supporting Documentation:*	*Approved? (KP Use Only)*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
		Total Requested (Not to exceed $5,000):			
		Total Approved (KP use only):			

For KP Use Only:			
Request Approver:		Request Process Date:	
Request Status:	Approved: ☐ Denied: ☐ Modified: ☐	Request Transmission Date:	

KAISER PERMANENTE®

Meals/Medically Tailored Meals

Complete page if this Community Supports is marked with an "X" on page 1.

Is member experiencing malnutrition or under nutrition? ☐ YES ☐ NO ☐ UNSURE

Does member have any of the following chronic conditions (select all that apply):

☐ Cancer ☐ Cardiovascular disorders ☐ Chronic lung disorders ☐ Chronic or disabling mental/behavioral disorders ☐ Congestive heart failure ☐ COVID post discharge	☐ Diabetes ☐ End stage renal disease ☐ Gestational Diabetes ☐ High risk perinatal conditions ☐ HIV ☐ Pulmonary Rehab ☐ Stroke	☐ Other, please specify:

How many times has the member been to an Emergency Department in the last 12 months? _____

How many times has member had an inpatient stay in the last 12 months? _____

If known, provide information about member's last discharge from a hospital or skilled nursing facility:

- Facility name: _____
- Date of discharge:_____

Does member need (or is already enrolled) in care coordination? (select one):

☐ No care coordination needed ☐ Basic care coordination ☐ Extensive/complex care coordination

Does member meet any of the exclusionary criteria for this service? (select all that apply):

☐ Members enrolled in another Medically Tailored Meal (MTM) program ☐ Member is in Hospice ☐ Member is in Skilled Nursing Facility ☐ Member is incarcerated.	☐ Member is unable to consume food and beverage orally ☐ Member is in Assisted Living Facility ☐ Member is in Board and Care ☐ Member is in Congregate Living Health Facility

KAISER PERMANENTE®

Nursing Facility Transition/Diversion to Assisted Living Facilities

Complete page if this Community Supports is marked with an "X" on page 1.

Is member currently in a nursing facility (select YES or NO and answer the follow-up questions below the selected response)?

☐ YES	☐ NO	
Admission Date	**Member meets minimum criteria to receive nursing facility level of care?**	☐ YES ☐ NO
Contact info for nursing facility		

Member Assessment (select YES or NO for each question):

Is the member willing to live in an assisted living setting as an alternative to a nursing facility?	YES ☐	NO ☐
Is the member able to reside safely in an assisted living facility with appropriate cost-effective supports?	YES ☐	NO ☐
Is the member interested in remaining in the community?	YES ☐	NO ☐
Is the member willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services?	YES ☐	NO ☐
Is the member currently receiving medically necessary nursing facility level of care?	YES ☐	NO ☐
Has the member applied for the Assisted Living Waiver?	YES ☐ Application Submission Date:	NO ☐

Services Requested (select YES or NO for each question):

Assessment of member's housing needs and presenting options	YES ☐	NO ☐
Assessment of the member's needs to determine if enhanced onsite services at the Residential Care Facilities for Elderly (RFCE)/Adult Residential Facilities (ARF) are required to be safely and stably housed	YES ☐	NO ☐
Assistance in securing a facility residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history)	YES ☐	NO ☐
Assistance in communicating with facility administration and coordinate a move	YES ☐	NO ☐
Assistance in establishing procedures and contacts to retain facility housing	YES ☐	NO ☐

Personal Care and Homemaker Services

Complete page if this Community Supports is marked with an "X" on page 1.

Eligibility Criteria:

Member must meet at least **one** of the following criteria for Personal Care and Homemaker Services
☐ Member is at risk for hospitalization, or institutionalization in a nursing facility; or ☐ Member needs assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs) and has no other adequate support system; or ☐ Member has been approved for In-Home Supportive Services.
☐ Member is not receiving duplicative support from another State, local, or federally funded program.
☐ Member has consented to the Personal Care and Homemaker Services referral.

Has Member applied for In-Home Supportive Services (IHSS)?	☐ Yes ☐ No ☐ Not Eligible	IHSS Referral Date:
Was Member approved for IHSS?	☐ Yes ☐ No ☐ Pending ☐ N/A	IHSS Hours per Month:
Does Member require additional hours beyond what was approved by IHSS?	☐ Yes ☐ No ☐ N/A	IHSS Reassessment Date:
If Member is **NOT** eligible for IHSS, would Personal Care and Homemaker Services help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days)?	☐ Yes ☐ No ☐ N/A	If yes, please describe:

Note: This service cannot be utilized in lieu of referring to the IHSS program. Member must be referred to the IHSS program when they meet referral criteria.

Recuperative Care or Short-Term Post-Hospitalization Housing (STPHH) Services

Complete page if either of these Community Supports are marked with an "X" on page 1.

Admission Information:

Date of Admission:		Expected Discharge Date:	
Reason for Admission:			
Where Member Was Admitted:	☐ Inpatient Hospital ☐ Nursing Facility ☐ Substance use disorder treatment facility ☐ Mental health treatment facility ☐ Correctional facility ☐ Recuperative Care ☐ Other, please specify	Member at risk of re-admission?	☐ Yes ☐ No
		Any isolation needs?	☐ MRSA ☐ COVID ☐ TB ☐ Other (please specify)
Service Requested	☐ RECUPERATIVE CARE ☐ STPHH	# of Days Requested	

Member's Housing Status:

Member's Housing Status **(select one)**	☐ At risk of homelessness ☐ Homeless ☐ Chronically Homeless ☐ Member is not homeless	Member's Current Living Situation: **(select all that apply)**	☐ Alone with no formal supports ☐ Facing housing insecurity ☐ Housing jeopardizing health / safety ☐ Other (please specify)
Member currently receiving housing services?		☐ Yes, provider: ☐ No	

Member Assessment:

1.	Can Member self-represent (advocate for themselves)?	☐ Yes	☐ No
2.	Danger to self or others?	☐ Yes	☐ No
2.	Is member physically & mentally stable?	☐ Yes	☐ No
3.	Is member self-ambulatory (may use assistive device)?	☐ Yes	☐ No (please explain):
4.	Is Member independent with activities of daily living (ADLs)?	☐ Yes	☐ No (please explain):
5.	Can Member perform wound care independently (if applicable)?	☐ Yes	☐ No Home Health Required.
6.	Does Member require incontinence supplies?	☐ Yes Can self-care be completed independently?	☐ No
7.	Is Member using substances?	☐ Yes (please indicate which substances):	☐ No
8.	If #7 answered yes, is Member willing to abstain?	☐ Yes	☐ No
9.	Does member require coordination of additional services (i.e, PT, dialysis, etc.)?	☐ Yes Please indicate which services:	☐ No
10.	Any additional relevant information:		

Additional Services Needed (i.e., Home Health, Physical Therapy, Dialysis, Transportation, etc.):

Service Type	Provider	Phone Number	Appointment Date/Time

To the best of your knowledge, has member previously received either Community Support (select one):

Recuperative Care: □ YES □ NO □ DON'T KNOW	STPHH: □ YES □ NO □ DON'T KNOW
If yes, when and with which provider?	