Community Supports
Recuperative Care (Medical Respite)

Recuperative Care, also known as Medical Respite, assists members who need short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

Send the completed referral via secure fax to **UM Prior Auth Fax to: 800-811-4804**

***This form must be completed in its entirety to be valid. Incomplete forms will not be processed.**

CS Service Information:		
CS Service Start Date[1]:	CS Service End Date:	
CS Service Urgency: ☐URGENT ☐ ROUTINE		
Community Support Service:	CS Service CPT Code:	Modifier:
Diagnosis:	Diagnosis Code:	
Requested Provider (if known):		
Special Notes/Comments:		

Eligibility Criteria:

Molina Enrollment: ☐ Medi-Cal member active with Molina

☐ CA DSNP EAE (Duals members active with Molina for Medicare and Medi-Cal)

☐ CA DSNP Non-EAE (Duals member active with Molina for Medi-Cal)

☐ **Member must meet the following criteria:**

- Member requires short-term residential care to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

AND <u>one</u> of the five (5) following criteria:

☐ Member is at risk of hospitalization or is post-hospitalization and lives alone with no formal supports.

☐ Member is at risk of hospitalization or is post-hospitalization and facing housing insecurity or have housing that would jeopardize their health and safety without modification.

☐ Member meets the HUD definition of homelessness **AND** one of the following:

- ☐ Enrolled in ECM.
- ☐ Have a serious chronic condition, or serious mental illness.
- ☐ At risk for institutionalization or require residential services as a result of SUD.

☐ Member meets the HUD definition of at risk of homelessness.

☐ Member is at risk of experiencing homelessness **AND** one of the following:

- ☐ Have one or more serious chronic condition or serious mental illness.
- ☐ At risk for institutionalization or require residential services because of SUD or Serious Emotional Disturbance.
- ☐ Enrolled with ECM.
- ☐ Transition-Age Youth with significant barriers to housing stability.

Recuperative Care Reason:

☐ Member/Authorized Representation consented to Recuperative Care services.

Patient Admit Date: Patient Pending or Discharge Date:

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Requestor Information:	
Referrer: ☐ Hospital/SNF ☐ PCP/Clinic ☐ IPA ☐ ECM ☐ Molina CM ☐ Other:	
Referrer Organization Name:	
Referrer Name:	Title:
Referrer Phone Number:	Fax Number:
Member Information:	
Member Name:	DOB:
Medi-Cal ID:	Preferred Language:
Cell Phone Number:	
Alternate Contact Name:	Phone #:
Living Situation: ☐ Shelter ☐ Car ☐ Streets/Encampment ☐ Jail/Prison ☐ Family/Friends ☐ Other:	
Income: ☐ SSI ☐ GR ☐ Other:	Amount:
Describe member's goals around housing:	
Last permanently housed date:	
Physical/Behavioral Information:	
Independent with ADLs/IADLs: ☐ Yes ☐ No Bowel and Bladder Continent: ☐ Yes ☐ No Self-Administer All Medications: ☐ Yes ☐ No	If no, describe:
Mobility: ☐ Independent ☐ Modified Independent If yes, describe: Assistive Device: ☐ Yes ☐ No	
PPD/TB Test or Chest X-Ray Date: COVID Test Date:	Outcome: Outcome:
Wounds ☐ Yes ☐ No Post-Discharge Treatment Plan: Home Health Vendor:	Number/Location/Size/Stage: Phone #:
Currently: ☐ Auditory/Visual Hallucinations ☐ Non-Compliant ☐ Forgetful ☐ Cognitive Impairment ☐ Registered Sex Offender ☐ Other: If checked, please describe:	
Colostomy/Ileostomy: ☐ Yes ☐ No Foley Catheter: ☐ Yes ☐ No Independent: ☐ Yes ☐No If no to independent, describe:	
O2: ☐ Yes ☐ No Concentrator: ☐ Yes ☐ No If yes, describe including saturation:	
Diabetic: ☐ Yes ☐ No If yes, independent with: ☐ Insulin ☐ Glucose Check ☐ Injectable Med	
Communicable Disease: ☐ Yes ☐ No If yes, describe:	Needs Isolation: ☐ Yes ☐ No
Prescribed Anticoagulants: ☐ Yes ☐ No	

[1] Community Support Service dates cannot overlap with an existing active authorization for the same service. Overlapping requests may be returned to the requester to revise service dates.

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INR/PT/PIT checks required: ☐ Yes ☐ No
Substance Abuse: ☐ None ☐ Alcohol ☐ Cocaine ☐ Heroin ☐ Methamphetamines ☐ Other: Last Use: Currently Withdrawing: ☐ Yes ☐ No Methadone Clinic: ☐ Yes ☐ No Clinic Information: Describe member's thoughts about treatment and/or abstaining:

☐ **Comprehensive medication list for all referred members is attached**.
Attached Docs: ☐ Face Sheet ☐ H&P ☐ Psych Notes ☐ Surgical Notes ☐ PT/OT Eval ☐ SW Notes

Follow-Up Appointments:

Provider Name and Specialty	Phone Number	Appt. Date/Time	Reason	Address