ASSISTED LIVING FACILITY TRANSITION REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org** or fax to **1(415) 615-6400**

San Francisco Health Plan℠

ASSISTED LIVING FACILITY (ALF) TRANSITIONS is a Community Supports service offered to eligible Medi-Cal members. This service is to assist eligible members to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. This service does not include room and board.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF), this service will include wrap-around services as follows: assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. This service also includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

This service also includes time-limited transition services and expenses to enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF. The transitional period will vary in length and services provided based on a member's unique circumstances. Allowable expenses are those necessary to enable a person to establish ALF residence (except room and board).

If this is a self-referral, please call San Francisco Health Plan's (SFHP) Care Management Intake line during business hours of 8:30am–5:00pm, Monday–Friday: **1(415) 615-4515,** and an SFHP staff member can assist you.

If the referral is being completed by a provider or other agency, please complete this form, and securely email to the SFHP Management department at **caremanagement_referrals@sfhp.org** or fax to **1(415) 615-6400.**

MEMBER/PATIENT INFORMATION Member must already be enrolled with SFHP for their Medi-Cal coverage	
First Name:	Last Name:
Date of Birth (MM/DD/YYYY):	Preferred Language:
SFHP ID#:	Referral Date:
Primary Phone Number:	Alternate Phone Number:
Address:	

REFERRING ENTITY INFORMATION ***Required fields**

☐ PCP/Specialist	☐ Friend/Family
☐ Community Based Organization	☐ Hospital
☐ Community Supports Provider	☐ Self
☐ ECM Provider	☐ Social Services Provider
☐ Medical Officer	☐ Other: (please specify)
*Referring Individual Name:	*Referring Individual Title:
*Referring Individual Phone Number:	*Referring Individual Email Address:
*Referring Organization Name:	*Referring Individual National Provider Identifier (NPI):

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ELIGIBILITY CRITERIA

Has the patient/member been informed that a Community Supports referral is being requested? (please select one)

- ☐ Yes. If Yes, has the member given approval to continue with this service?
  - ☐ Yes
  - ☐ No
- ☐ No

Is the member enrolled in Enhanced Care Management (ECM)?

- ☐ Yes
- ☐ No

Is the member on the waitlist for an Assisted Living Waiver?

- ☐ Yes
- ☐ No

Time-limited transition services and expenses are to enable a person to establish a residence in an ALF (except room and board). Does the member need assistance with these expenses?

- ☐ Yes. If Yes, please fill out **prior approval form** included in this referral.
- ☐ No

ELIGIBILITY CRITERIA
Nursing Facility Transition (members residing in nursing facility)

● If No is checked for any of the following, **STOP.** Member does not meet eligibility requirement.

1. **Has the member resided in a skilled nursing facility for 60 or more days or resided in a hospital for 60 or more days receiving skilled nursing facility level care?**
   - ☐ Yes. If Yes, please provide: Date of transmission: Date of discharge:
   - ☐ No
2. **Is the member willing to live in a Residential Care Facility for Elderly or assisted living facility instead of a skilled nursing facility which would require member to pay a portion of income for room and board?**
   - ☐ Yes
   - ☐ No
3. **Does the member require assistance completing Activities of Daily Living (ADLs) such as meals, medication administration, transportation, etc.?**
   - ☐ Yes. If Yes, please descried the level of care that is needed:
   - ☐ No

ELIGIBILITY CRITERIA
Nursing Facility Diversion (members residing in the community)

● If No is checked for any of the following, **STOP.** Member does not meet eligibility requirement.

1. **Does the member desire to remain in the community?**
   - ☐ Yes
   - ☐ No
2. **Is the member willing and able to reside in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place?**
   - ☐ Yes
   - ☐ No
3. **Please describe the level of care that the member requires to remain in the community:**

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ATTESTATION STATEMENT

☐ **I, the referent, attest that to the best of my knowledge; the member meets the eligibility criteria and does not fall within the exclusion criteria.**

Signature:	Today's Date (MM/DD/YYYY):

COMMUNITY SUPPORTS PRIOR APPROVAL FORM

FOR HOUSING DEPOSITS, HOME MODIFICATION, ASSITED LIVING FACILITY TRANSITIONS AND TRANSITION TO COMMUNITY SERVICES

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED

TYPED ONLY - NO HANDWRITTEN FORMS

Select all that apply: ☐ New Request ☐ Modify Prior Request

Select applicable CS service: ☐ Housing Deposits ☐ Home Modifications ☐ Community Transitions Service (At least one valid CS service is required)

PATIENT		RENDERING PROVIDER	
Name*:		Name*:	
SFHP ID#*:	Date of Birth*:	Telephone*:	
Telephone:		**Contact Name:**	Fax:
Address:		Address:	

JUSTIFY THE GOODS/SERVICES AND DESCRIBE HOW THEY MEET MEMBER NEEDS*

COMMUNITY SUPPORTS SERVICE TYPES

☐ Housing Deposits ☐ Home Modifications ☐ Community Transitions Service (At least one valid CS service is required)

QTY OF ITEM	NAME OF ITEM	DESCRIPTION	VENDOR (Amazon, IKEA, etc.)	COST PER UNIT	TOTAL COST

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Please verify eligibility using one of the following methods: 1. Web: **sfhp.org/providers** 2. Interactive Voice Response: **1(415) 547-7810** 3. SFHP Customer Service: **1(800) 288-5555**

Comments:

Signature*: Submission Date*:

Important: Please attach appropriate documentation to support your request.