TRANSITIONS TO COMMUNITY REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

Community Transition Services and Nursing Facility Transition to a Home are Community Support Services offered to eligible Medi-Cal members. Community Transition Services and Nursing Facility Transition to a Home refer to one-time costs incurred when individuals move from a licensed facility to a private residence, where they take on full responsibility for their living expenses.

These allowable expenses encompass the essential items needed for establishing a basic household and do not cover costs such as rent, room, and board. This service is limited to a lifetime maximum of $7,500.

If this is a self-referral, please call San Francisco Health Plan's 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 and fax to **1(415) 615-6400** or securely email to San Francisco Health Plan's Care Management department at **caremanagement_referrals@sfhp.org**.

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

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

1. Is the member currently receiving medically necessary nursing facility care and want to return home while continuing to receive this care?
   - ☐ Yes
   - ☐ No
2. **Has the member been in a nursing home or Medical Respite setting for more than 60 days?**
   - ☐ Yes. If Yes, please provide: Date of admission: Date of discharge/Anticipated discharge:
   - ☐ No
3. **Can the member safely live in the community with appropriate and cost-effective support?**
   - ☐ Yes
   - ☐ No
4. **Please briefly summarize the member's discharge plan, including identified supports and location of residence in the community.** (can also attached a copy of the discharge plan that identifies supports and location of residence in the community).

Additional comments:

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

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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.