TRANSITIONS TO COMMUNITY REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
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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 SFHP's Care Management Intake line during business hours of 8:30am to 5:00pm, Monday–Friday: **1(415) 615-4515**. Completed forms can be securely emailed 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

- ☐ PCP/Specialist
- ☐ Community Based Organization
- ☐ Community Supports Provider
- ☐ ECM provider
- ☐ Friend/Family
- ☐ Hospital
- ☐ Self
- ☐ Other (please specify):

Name:	Phone Number:
Address:	Email:

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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
   - ☐ No

   If Yes, please provide:

   Date of admission Date of discharge/Anticipated discharge
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):