HOME MODIFICATIONS REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

Home Modifications are Community Support Services offered to eligible Medi-Cal members. Services are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home, without which the Member would require institutionalization.

All approved referrals include an OT evaluation through a San Francisco Health Plan (SFHP) delegated third party. The member must consent to this in person evaluation to receive services.

If this is a self-referral, please call SFHP'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 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

1. **Is the member at risk for institutionalization in a nursing facility, or living in the community and at risk for hospitalization without home modifications?**
   - ☐ Yes
   - ☐ No

● If No is checked, **STOP**. Member does not meet eligibility requirement.

2. **Briefly describe the member's needs and how home modifications may be able to assist.**

3. **Has the member been informed and agreed to the in-person OT evaluation to determine what home modifications are needed?**
   - ☐ Yes
   - ☐ No

4. **To your knowledge, has the member previously received home modifications services under Community Supports?**
   - ☐ Yes. If Yes, which Health Plan or provider?
   - ☐ No

5. **Required supporting documentation:**

   Community Supports Prior Approval form must come from PCP/Clinician specifying the need requested home modifications equipment or service

   Note: Referral cannot be processed without documentation

ATTESTATION STATEMENT

☐ **I, the referent, attest that to the best of my knowledge; the member meets the eligibility criteria for home modifications and have attached the required documentation from the member's PCP with this referral.**

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.