HOME MODIFICATIONS REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
Here for you

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.

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 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

- ☐ 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

1. **Is the member at risk for institutionalization in a nursing facility and currently living in the community?**
   - ☐ 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. **To your knowledge, has the member previously received home modifications services under Community Supports?**
   - ☐ Yes
   - ☐ No

   If Yes is checked, which Health Plan or provider?

4. **Required supporting documentation:**
   - ☐ Order from PCP 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):