RESPITE SERVICES REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN
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Respite Services are Community Supports services offered to eligible Medi-Cal members. Respite Services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those people who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

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) 615-4501**, 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:	

Is the member being discharged from a hospital or Skilled Nursing Facility?

☐ No

☐ Yes (qualifies for expedited review, (3 business days))

If Yes, identify the Navigation Services provider:

REFERRING ENTITY INFORMATION

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

Name:	Phone Number:
	Email:
Current Caregiver Name:	Current Caregiver Phone Number:
	Current Caregiver Email:

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ELIGIBILITY CRITERIA

Adult (21+)

To qualify, members must meet at least one of the eligibility criteria below. Please select all that apply:

1. **Does the member live in the community and require assistance with Activities of Daily Living (ADLs)?**
   - ☐ Yes
   - ☐ No
2. **Is the member dependent upon a caregiver who provides most of their support, and who requires caregiver relief to avoid institutional placement?**
   - ☐ Yes
   - ☐ No
3. **Does member have complex care needs and relief for the primary caregiver will avoid institutional placement?**
   - ☐ Yes

     If Yes, please describe complex care needs:

   - ☐ No

Members must indicate what service(s) is/are required. Please select all that apply:

- ☐ Services needed by the hour on an episodic basis because of the absence of or need for relief for those people normally providing care to individuals.
- ☐ Services needed by the day/overnight on a short-term basis because of the absence of or need for relief for those people normally providing the care to individuals.
- ☐ Services needed to attend to the member's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.
- ☐ Services needed for the member in their own home, or another location being used as the home.
  Address of location:
- ☐ Facility Respite Services needed in an approved out-of-home location.
  Address of location:

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ELIGIBILITY CRITERIA (continued)

Child or Youth (Under 21)

To qualify, members must meet at least one of the eligibility criteria below. Please select all that apply:

Please select any of the following that may apply:

- ☐ Member previously received respite service under the Pediatrics Palliative Care Waiver
- ☐ Member is enrolled in the California Children's Services (CCS)
- ☐ Member is enrolled in the Genetically Handicapped Persons Program (GHPP)
- ☐ Member is a foster care program beneficiary
- ☐ Member has complex care needs and relief for the primary caregiver will avoid institutional placement
  If the above box is checked, please describe the member's complex care needs:

Members must indicate what service(s) is/are required. Please select all that apply:

- ☐ Services needed by the hour on an episodic basis because of the absence of or need for relief for those people normally providing care to individuals.
- ☐ Services needed by the day/overnight on a short-term basis because of the absence of or need for relief for those people normally providing the care to individuals.
- ☐ Services needed to attend to the member's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.
- ☐ Services needed for the member in their own home, or another location being used as the home.
  Address of location:

- ☐ Facility Respite Services needed in an approved out-of-home location.
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ELIGIBILITY CRITERIA (continued)

1. **When are the services needed? (please select one)**
   - ☐ Urgently (within 3 business days)
   - ☐ Within next two weeks
   - ☐ Within the next month
2. **Has the caregiver/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
3. **Is the member currently receiving In-Home Support Services (IHSS)? (please select one)**
   - ☐ Yes
     - If Yes, how many hours is the member receiving?
   - ☐ No
4. **Is the member currently attending any of the following? (please select one)**
   - ☐ Adult Day Center/CBAS
   - ☐ Golden Gate Regional Center or similar facility
   - ☐ Other (please specify):
5. **Has the member received respite services in the past year?**
   - ☐ Yes
   - ☐ No

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):