Community Supports – Medical Respite Approval Request Form

The Alameda Alliance for Health (Alliance) Community Supports (CS) Department – Medical Respite Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for CS medical respite services, please coordinate and receive acceptance to the medical respite facility first, before completing the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Attach a clinical summary and/or supporting documentation (ex. clinic notes, hospital discharge summary, etc.), providing justification for medical respite services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Office Contact Name: _____ Today's Date: _____

☐ Referred by Clinician (RN, MD, PCP, NP, etc.) Date of Admission: _____

Level of Urgency (please select only one (1): ☐ Routine ☐ Urgent ☐ Retro

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Primary Diagnosis Requiring Medical Respite (including ICD-10 Code):

_____

☐ Confirmed patient is not receiving duplicative support from other state, local, or federally funded programs, and these programs have been considered first before using Medi-Cal funding.

Is the member currently linked to a case management team?

☐ Yes, *please provide the name and phone number of the case manager or team*:

_____

☐ No

Is the member participating in or well-linked with other case management services?

☐ Yes

☐ No

Please describe the member's current case management situation:

Patient's Qualifying Condition(s) (please select all that apply and provide supporting documentation. The patient must meet at least one (1) qualifying condition to be eligible):

☐ Meets the Housing and Urban Development (HUD) definition of homeless as defined in section 91.5 of Title 24 of the Code of Federal Regulations:
www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

☐ Is alert and oriented to name, place, and situation (respites cannot accommodate wanderers).

☐ Has unstable living situations and is too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment, but are not otherwise ill enough to be in a hospital, or refuses to go to a medical facility for treatment.

☐ At risk of hospitalization or is post-hospitalized, and lives alone with inadequate or no formal supports.

☐ Facing housing insecurity or has housing that would jeopardize their health and safety without modification.

☐ Indications for respite referrals – needs medical services that could be reasonably accessed in a sheltered setting (i.e., chemo).

Requesting Services:

- ☐ Interim housing with a bed and meals, ongoing monitoring of the individuals' ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring), and wrap-around social services.

Rendering Provider (please select only one (1)):

- ☐ BACS (NPI Number: **1952697732**)
- ☐ Cardea Health (NPI Number: **1538823646**)
- ☐ Lifelong Medical Respite (NPI Number: **1568598829**)