Caregiver Respite Services
Approval Request Form

The Alameda Alliance for Health (Alliance) Caregiver Respite Services 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 caregiver respite services, please complete 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 (e.g., clinic notes, hospital discharge summary, etc.), justifying caregiver 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: _____ Date of Request: _____

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 Caregiver Respite Services (including ICD-10 Code):

☐ Confirm (to the best of your knowledge) that the member 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 (Please Note: Your member will be referred to the Alliance Case Management team)

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

☐ Yes
☐ No

Please describe the member's current case management situation:

Member's Qualifying Condition(s) (please select all that apply and provide clinical notes to support justification):

☐ Member is currently living in the community and is compromised in their Activities of Daily Living (ADLs)
☐ Member is dependent upon a qualified caregiver who provides the most of their support and requires caregiver relief to avoid institutional placement
☐ Member has been previously covered for respite services under (if appropriate, please select all that apply):
  ☐ California Children's Services (CCS)
  ☐ Foster Care Program
  ☐ Genetically Handicapped Persons Program (GHPP)
  ☐ Pediatrics Palliative Care Waiver
☐ Member has complex care needs

Requesting Services (please select all that apply):

- ☐ Rest for the caregiver only
- ☐ Short-term services because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical
- ☐ Services provided (please select all that apply):
  - ☐ In member home
  - ☐ In another location being used as the home:

    Name of location:_____

Rendering Provider:

- ☐ 24-Hour Home Care (NPI Number: 1376797035)