Community Supports – Referral Form

Please use this form to refer Alameda Alliance for Health (Alliance) Medi-Cal and Alameda Alliance Wellness (HMO D-SNP) members to Community Supports services. This form is confidential.

The provider is responsible for verifying the members' eligibility on the date of service. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal.

To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click the Provider Portal button in the top-right corner of our home page. You will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond. If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**.

Instructions

1. Please print clearly or type in all the fields in Sections 1 and 2 below.
2. In Section 3, please select the Community Supports services that the member is interested in receiving. Select all required checkboxes for the selected services prior to submission.
3. Submit the completed form and any supporting documentation to the Alliance Community Supports Department via fax at **1.510.995.3726** or secure email at **CSDept@alamedaalliance.org**.

Please Note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. For questions, please call the Alliance Community Supports Department at **1.510.747.4545**.

Referral Date: _____

Section 1: Referrer Information

Last Name: _____ First Name: _____

Agency or Relationship to Member: _____

National Provider Identifier (NPI): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Section 2: Member Information

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____

Alliance Member ID Number: _____ Client Index Number (CIN): _____

Medicare Beneficiary Identifier (MBI): _____

Primary Care Provider (PCP) Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Primary Diagnosis (including ICD-10 code(s)): _____

Email: _____

Preferred Written Language: _____

Preferred Spoken Language: _____

Is the member currently in the hospital? ☐ Yes ☐ No

Section 3: Community Supports Services

Housing Services
(To initiate the Coordinated Entry process, please dial **2-1-1**)

Service Type	Requirements
☐ **Housing Deposit –** Identifies, coordinates, and funds move-in costs and services for a basic household, excluding room and board.	Eligibility criteria: • Individuals who meet the **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2; **OR** • Individuals who are determined eligible for *Transitional Rent*. These individuals are automatically eligible for Housing Deposits; **OR** • Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Section 3: Community Supports Services	
Housing Services (cont.) (To initiate the Coordinated Entry process, please dial **2-1-1**)	
Service Type	**Requirements**
☐ **Housing Tenancy and Sustaining Services (HTTS) –** Provides education, coaching, and support to maintain a safe and stable tenancy once housing is secured.	Eligibility criteria: • Individuals who meet the **Social Risk Factor** requirements (the U.S. HUD definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2; **OR** • Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTTS; **OR** • Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.
☐ **Housing Transition Navigation Services (HTNS) –** Assist members with obtaining housing and preparing for move-in.	Eligibility criteria: • Individuals who meet the **Social Risk Factor** requirements (the U.S. HUD definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2; **OR** • Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS; **OR** • Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Section 3: Community Supports Services	
Housing Services (cont.) (To initiate the Coordinated Entry process, please dial **2-1-1**)	
Service Type	**Requirements**
☐ **Transitional Rent** – Assist members with up to six (6) months of rental assistance payments.	Eligibility criteria: • Individuals who meet the **Social Risk Factor** requirements (the U.S. HUD definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2; **AND** • Individuals who meet the Transitioning Population Requirement; **OR** • Individuals who are experiencing unsheltered homelessness; **OR** • Individuals who are eligible for Full-Service Partnership (FSP). Individuals must also meet the population of focus as determined by the Alliance.
In-Home Services	
Service Type	**Requirements**
☐ **Asthma Remediation** – Provides information for members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and provides needed equipment.	Please select all that apply: ☐ Member had an emergency department (ED) visit or hospitalization in the past 12 months. ☐ Member had two (2) sick or urgent care visits in the past 12 months. ☐ Member has a score of 19 or lower on the Asthma Control Test. ☐ Member is open to the Asthma Preventive Service benefit. ☐ PCP has documented the medical need for this service and will provide documentation upon request. Member received this service before: ☐ Yes ☐ No ☐ Unsure

Section 3: Community Supports Services	
In-Home Services (cont.)	
Service Type	**Requirements**
☐ **Environmental Accessibility Adaptations** – Provides physical adaptations to a home that are necessary to ensure the health, welfare, and safety of members or that enable members to remain in their home.	Please select all that apply: ☐ Member is at risk for institutionalization in a nursing facility; **AND** ☐ Member has discussed needing a home modification with their PCP. ☐ PCP has documented the medical need for this service and will provide documentation upon request. Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Medically-Tailored Meals** – Provide members with medically-tailored meals at home after discharge from a hospital or nursing home.	Eligibility criteria: • Member has a nutritional sensitive condition. Please list the member's conditions (including ICD-10 codes if known): _____ Please select all that apply: ☐ Member is interested in a produce prescription. ☐ Member is interested in medically supportive food. ☐ Member is interested in medically-tailored grocery boxes. ☐ Member is interested in pre-made, medically-tailored meals. ☐ Member is on a special diet. If selected, please describe: _____ ☐ Member is interested in Nutritional Counseling Member has a refrigerator: ☐ Yes ☐ No Member has a microwave: ☐ Yes ☐ No

Section 3: Community Supports Services	
In-Home Services (cont.)	
Service Type	**Requirements**
☐ **Personal Care and Homemaker Services** – Provide members who need help with activities of daily living (ADLs) with personal care and homemaker services.	Please select all that apply: ☐ Member has functional deficits and no adequate support system. ☐ Member is at risk for hospitalization or institutionalization in a nursing facility. Please select only one (1): ☐ Member has applied for In-Home Supportive Services (IHSS) and is waiting to have the assessment completed. ☐ Member is approved for IHSS **and** has requested an increase in hours that is still pending. ☐ Member is not eligible for IHSS. Family member or friend interested in becoming a caregiver: ☐ Yes ☐ No
☐ **Respite Services** – Provides respite services to unpaid caregivers of members who require intermittent temporary supervision. This service is distinct from medical respite or recuperative care and provides rest for the caregiver only. The limit is 336 hours per year.	Eligibility criteria: • In-home respite services are provided to the member in their own home or another location being used as the home. • Dependent on a qualified caregiver and without one, the member would need to be in a nursing facility. The member has specific dates and times for needing a respite caregiver: Start Date: _____ End Date: _____ Hours: _____ The member has other services that provide a caregiver (please select all that apply): ☐ Community-Based Adult Services (CBAS) ☐ In-Home Supportive Services (IHSS) ☐ Private Caregiver ☐ Regional Center

Section 3: Community Supports Services	
Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission	
Service Type	**Requirements**
☐ **Community Transition Services** – Provides nursing facility transition to a home.	Eligibility criteria: • Member is currently receiving medically necessary nursing facility Level of Care (LOC) services and, in lieu of remaining in the nursing facility or medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services • Member is interested in moving back to the community. • Member is willing and able to reside safely in the community with appropriate and cost-effective supports and services. • Member resided 60+ days in a nursing home or medical respite setting. Member meets **ALL** criteria in this section: ☐ Yes ☐ No Member received this service before: ☐ Yes ☐ No ☐ Unsure
☐ **Nursing Facility Diversion/Transition to Assisted Living Facility** – Place members who, without this support, would need to reside in a nursing facility and instead transition them into a Residential Care Facility for the Elderly (RCFE) or Adult Residential Facility (ARF).	Eligibility criteria: • Member is currently receiving medically necessary nursing facility LOC services or meets the minimum criteria to receive those services in an assisted living facility. • Member is interested in remaining in the community. • Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective support and services. Member meets **ALL** criteria in this section: ☐ Yes ☐ No Member received this service before: ☐ Yes ☐ No ☐ Unsure

Section 3: Community Supports Services	
Services Provided for Post-Acute Care Admission or Post-Nursing Facility Admission (cont.)	
Service Type	**Requirements**
☐ **Recuperative Care –** Provides short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury, illness, or mental health condition.	Please select only one (1): ☐ Member faces housing insecurity or has housing that would jeopardize the member's health and safety without modification. ☐ Member is at risk of homelessness with significant barriers to housing that meet at least one (1) of the following: • Has a serious mental illness. • Has one (1) or more serious chronic conditions. • Is at risk of institutionalization or overdose, or requires residential services because of a substance use disorder, or has a serious emotional disturbance (children and adolescents). • Is a transition-age youth with significant barriers to housing stability, such as one (1) or more convictions, a history of foster care, involvement with the juvenile justice or criminal system, and/or been a victim of trafficking or domestic violence. • Is receiving Enhanced Care Management (ECM). ☐ Member is at risk of hospitalization or is post-hospitalization. ☐ Member lives alone with no formal support. ☐ Member meets the HUD definition of homeless or is at risk of homelessness.