

## HPSM Community Supports Request Information Form

This form must be submitted with Prior Authorization Request Form. *Note: Member must meet the basic qualifications (active HPSM Medi-Cal or CareAdvantage, engaged with a Care Manager and willing to receive Community Support) to be eligible for Community Supports.*

### Step 1: Fill out all applicable information then proceed to Step 2.

MEMBER'S INFORMATION		
Member's Last Name:	Member's First Name:	
Date of Birth:	Language:	
Phone:	<input type="checkbox"/> Member speaks English <input type="checkbox"/> Member does not speak English	
Email:	Preferred Language: _____	
Home Address:	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> CareAdvantage	
HPSM ID #:	<input type="checkbox"/> Meets basic qualifications as listed above	
REFERENT INFORMATION		
First Name:	Agency/Org/Facility Name:	
Last Name:	Relationship to Member:	
NPI #:	<input type="checkbox"/> ECM Provider	
Phone:	<input type="checkbox"/> Care Manager	
Email:	<input type="checkbox"/> Primary Care Provider	
Fax:	Other provider, please describe: _____	
<input type="checkbox"/> Member or authorized support person provided consent to request for Community Supports	Is member enrolled in ECM? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ECM provider: _____ <i>List of our ECM providers: <a href="http://www.hpsm.org/provider/calaim">www.hpsm.org/provider/calaim</a></i>	
Please provide a brief description regarding member's presenting issues to result in need for Community Supports:		
REFERENT INFORMATION		
If requesting Medically Tailored Meals only, please complete this section selecting all allergens that apply: <input type="checkbox"/> Milk <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Tree nuts <input type="checkbox"/> Egg <input type="checkbox"/> Peanuts <input type="checkbox"/> Soy wheat <input type="checkbox"/> Other: _____		
Desired Meal Type:	Primary	Secondary (optional)
General Wellness – General Default Vegetarian (includes dairy, eggs, plant protein, nuts and beans - Vegan not available)	<input type="checkbox"/>	<input type="checkbox"/>
Lower Sodium (sodium 600, protein >25g)	<input type="checkbox"/>	<input type="checkbox"/>
Heart-Friendly (sodium <10%)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes-Friendly (carbs <65%/entrée, 100g/meal)	<input type="checkbox"/>	<input type="checkbox"/>
Renal-Friendly (sodium <700mg, potassium <833 mg, phosphorus <300mg)	<input type="checkbox"/>	<input type="checkbox"/>
Gluten-Free (tested less than 20ppm, not a dedicated kitchen)	<input type="checkbox"/>	<input type="checkbox"/>
Protein+ (calories >600, protein >25g)	<input type="checkbox"/>	<input type="checkbox"/>
Vegetarian (includes dairy, eggs, plant protein, nuts, beans - vegan not available)	<input type="checkbox"/>	<input type="checkbox"/>
Puréed (for dysphagia patients and those with difficulty swallowing)	<input type="checkbox"/>	<input type="checkbox"/>
Shelf-Stable Meals (not medically-tailored)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Special delivery instructions, please describe: _____		

**Step 2: Select the Community Supports service(s) requested and check all member eligibility criteria below each service selected that apply then proceed to Step 3.** See webpage for description of services: [www.hpsm.org/provider/calaim](http://www.hpsm.org/provider/calaim)

MEMBER COMMUNITY SUPPORTS SERVICE CRITERIA INFORMATION	
Program Name	Eligibility Criteria (select all that apply):
<input type="checkbox"/> <b>Housing Transition Navigation Services</b>	<input type="checkbox"/> Homeless/at risk of homelessness. <input type="checkbox"/> Prioritized for permanent supportive housing or rental subsidy through San Mateo County system/resource. <input type="checkbox"/> Receiving Enhanced Care Management.
<input type="checkbox"/> <b>Housing Deposit</b> <i>*Member must be receiving Housing Transition Navigation Services. Available once in a lifetime.</i>	<input type="checkbox"/> Received Housing Transition Navigation Services. <input type="checkbox"/> Prioritized for permanent supportive housing or rental subsidy through San Mateo County or other resource. <input type="checkbox"/> Homeless/at risk of homelessness. <input type="checkbox"/> Receiving Enhanced Care Management.
<input type="checkbox"/> <b>Housing Tenancy and Sustaining Services</b> <i>*Available a single duration in a lifetime.</i>	<input type="checkbox"/> Received Housing Transitions Navigation Services. <input type="checkbox"/> Prioritized for permanent supportive housing or rental subsidy through San Mateo County system/resource. <input type="checkbox"/> Receiving Enhanced Care Management.
<input type="checkbox"/> <b>Environmental Accessibility Adaptations (Home Modifications)</b> <i>* May not receive duplicative support from state, local or federal program (e.g., HCBA Waiver), consider other funding before Community Supports.</i>	<input type="checkbox"/> Received PT/OT evaluation supporting medical necessity. <input type="checkbox"/> Has PCP or other health professional Rx/order for medically necessary equipment or service.
<input type="checkbox"/> <b>Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFE)</b> <i>*May not receive duplicative support from state, local or federal program (e.g., ALW Waiver), consider the above funding before Community Support.</i>	<b>SNF Transition:</b> <input type="checkbox"/> Residing in SNF for 60+ days. <input type="checkbox"/> Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place. <b>SNF Diversion:</b> <input type="checkbox"/> Desires to remain in the community. <input type="checkbox"/> Meets minimum criteria for SNF level of care. <input type="checkbox"/> Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place.
<input type="checkbox"/> <b>Community Transition Services/ Nursing Facility Transition to a home</b> <i>*May not receive duplicative support from state, local or federal funding (e.g., ALW Waiver), consider the above funding before Community Support.</i>	<input type="checkbox"/> Residing in SNF or medical respite setting for 60+ days. <input type="checkbox"/> Desires to live in the community. <input type="checkbox"/> Willing and able to safely reside in community (home) setting with appropriate supports in place.
<input type="checkbox"/> <b>Medically Tailored Meals (MTM)</b> <i>*MTM is covered up to 2 meals per day for 12 weeks. Not intended to solely address food insecurity.</i>	<input type="checkbox"/> Has chronic conditions and/or disabling mental or behavioral health disorder. <input type="checkbox"/> Hospital or SNF discharge in the last 60 days, or planned for discharge. <input type="checkbox"/> Receiving Enhanced Care Management or has extensive care coordination needs.

*More Community Supports on the next page >>>*

## MEMBER COMMUNITY SUPPORTS SERVICE CRITERIA INFORMATION

Program Name	Eligibility Criteria (select all that apply):
<input type="checkbox"/> <b>Respite Services</b>	<input type="checkbox"/> Lives in the community and compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support and who require caregiver relief to avoid institutional placement.
<input type="checkbox"/> <b>Personal Care and Homemaker Services</b> <i>*This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.</i>	<input type="checkbox"/> At risk for hospitalization, or institutionalization in a nursing facility. <input type="checkbox"/> Has functional deficits and no other adequate support system. <input type="checkbox"/> Approved for In-Home Supportive Services.
<input type="checkbox"/> <b>Asthma Remediation</b> <i>*To complete authorization, please also submit a current licensed health care provider's order specifying the requested remediation(s) for the member; a brief written evaluation specific to the member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost effective"; and that a home visit has been conducted to determine the suitability of any requested remediation(s) for the member.</i>	<input type="checkbox"/> Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

☐ By checking this box, you attest that member meets the eligibility criteria for the Community Supports service(s) selected.

**Step 3: Attach this completed form to the Prior Authorization Request Form along with any supporting clinical documentation and fax to HPSM's Utilization Management Team. Fax number: 650-829-2079.**