RECUPERATIVE CARE REFERRAL FORM

Recuperative care (medical respite care) is short-term post-hospital residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. For more information, review the *Authorization Guide for Recuperative Care* available on provider.healthnetcalifornia.com > CalAIM Resources for Providers > *Forms & Tools* > *Authorizations*.

Complete and submit this referral form with the *Medi-Cal – Prior Authorization Request Form – Outpatient* online (recommended) at **provider.healthnetcalifornia.com** or by **fax at 800-743-1655**.

Select one:	☐ **Initial request** ☐ **Extension request** ☐ **Transfer**
Confirm member consent/attestation:	☐ **Member consented to recuperative care referral** ☐ **Member attests to need for housing and housing navigation services**

Member Information

Member name:		Phone number:
Medi-Cal ID:	Date of birth:	Preferred language:
Home address:		
Contact name (*if different than member*):		Phone number:
Relationship:		Preferred language:
(Optional) Member's ECM Provider name:		Phone number:

Explain member's need for recuperative care (initial, extension or transfer request). Note: Member's stay cannot exceed more than 90 days in continuous duration.

Community Supports Provider Information (Servicing Organization)

Organization name:	
Tax ID:	National provider identifier (NPI):
Staff name:	Title:
Phone number:	Fax number:

Eligibility Criteria

Select all that apply.

☐ Member is at risk of hospitalization.

☐ Member lives alone with no formal supports.

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

Required Documents

Submit documents with the referral form.

☐ Admission face sheet
☐ History and physical

OR

☐ Discharge summary from previous institution

OR

☐ Street medicine provider assessment