HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080
www.hpsm.org

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:	☐ Member speaks English ☐ Member does not speak English
Email:	Preferred Language: _____
Home Address:	☐ Medi-Cal ☐ CareAdvantage
HPSM ID #:	☐ Meets basic qualifications as listed above

REFERENT INFORMATION	
First Name:	Agency/Org/Facility Name:
Last Name:	Relationship to Member:
NPI #:	☐ ECM Provider
Phone:	☐ Care Manager
Email:	☐ Primary Care Provider
Fax:	Other provider, please describe: _____
☐ Member or authorized support person provided consent to request for Community Supports	Is member enrolled in ECM? ☐ Yes ☐ No If yes, ECM provider: _____ *List of our ECM providers: www.hpsm.org/provider/calaim*
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:

☐ Milk ☐ Fish ☐ Shellfish ☐ Tree nuts ☐ Egg ☐ Peanuts ☐ Soy wheat ☐ Other: _____

Desired Meal Type:	**Primary**	**Secondary (optional)**
General Wellness – General Default Vegetarian (includes dairy, eggs, plant protein, nuts and beans - Vegan not available)	☐	☐
Lower Sodium (sodium 600, protein >25g)	☐	☐
Heart-Friendly (sodium <10%)	☐	☐
Diabetes-Friendly (carbs <65%/entrée, 100g/meal)	☐	☐
Renal-Friendly (sodium <700mg, potassium <833 mg, phosphorus <300mg)	☐	☐
Gluten-Free (tested less than 20ppm, not a dedicated kitchen)	☐	☐
Protein+ (calories >600, protein >25g)	☐	☐
Vegetarian (includes dairy, eggs, plant protein, nuts, beans - vegan not available)	☐	☐
Puréed (for dysphagia patients and those with difficulty swallowing)	☐	☐

☐ 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**

MEMBER COMMUNITY SUPPORTS SERVICE CRITERIA INFORMATION	
Program Name	**Eligibility Criteria (select all that apply):**
☐ **Housing Transition Navigation Services**	☐ Homeless/at risk of homelessness. ☐ Prioritized for permanent supportive housing or rental subsidy through San Mateo County system/resource. ☐ Receiving Enhanced Care Management.
☐ **Housing Deposit** **Member must be receiving Housing Transition Navigation Services. Available once in a lifetime.*	☐ Received Housing Transition Navigation Services. ☐ Prioritized for permanent supportive housing or rental subsidy through San Mateo County or other resource. ☐ Homeless/at risk of homelessness. ☐ Receiving Enhanced Care Management.
☐ **Housing Tenancy and Sustaining Services** **Available a single duration in a lifetime.*	☐ Received Housing Transitions Navigation Services. ☐ Prioritized for permanent supportive housing or rental subsidy through San Mateo. County system/resource. ☐ Receiving Enhanced Care Management.
☐ **Environmental Accessibility Adaptations (Home Modifications)** ** May not receive duplicative support from state, local or federal program (e.g., HCBA Waiver), consider other funding before Community Supports.*	☐ Received PT/OT evaluation supporting medical necessity. ☐ Has PCP or other health professional Rx/order for medically necessary equipment or service.
☐ **Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFE)** **May not receive duplicative support from state, local or federal program (e.g., ALW Waiver), consider the above funding before Community Support.*	**SNF Transition:** ☐ Residing in SNF for 60+ days. ☐ Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place. **SNF Diversion:** ☐ Desires to remain in the community. ☐ Meets minimum criteria for SNF level of care. ☐ Willing and able to reside safely in an Assisted Living Facility/RCFE in lieu of SNF with appropriate supports in place.
☐ **Community Transition Services/ Nursing Facility Transition to a home** **May not receive duplicative support from state, local or federal funding (e.g., ALW Waiver), consider the above funding before Community Support.*	☐ Residing in SNF or medical respite setting for 60+ days. ☐ Desires to live in the community. ☐ Willing and able to safely reside in community (home) setting with appropriate supports in place.
☐ **Medically Tailored Meals (MTM)** **MTM is covered up to 2 meals per day for 12 weeks. Not intended to solely address food insecurity.*	☐ Has chronic conditions and/or disabling mental or behavioral health disorder. ☐ Hospital or SNF discharge in the last 60 days, or planned for discharge. ☐ 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):**
☐ **Respite Services**	☐ 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.
☐ **Personal Care and Homemaker Services** **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.*	☐ At risk for hospitalization, or institutionalization in a nursing facility. ☐ Has functional deficits and no other adequate support system. ☐ Approved for In-Home Supportive 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.