



CalAIM Short-Term Post-Hospitalization & Recuperative Care Referral Form

ELIGIBILITY CRITERIA

<u>Criterion</u>	Yes	No
Currently enrolled in Medi-Cal MCP with authorization for services	<input type="checkbox"/>	<input type="checkbox"/>
Planned discharge from inpatient facility (e.g. hospital, SNF, mental health facility)	<input type="checkbox"/>	<input type="checkbox"/>
Experiencing homelessness or at risk of homelessness	<input type="checkbox"/>	<input type="checkbox"/>
Needs temporary housing for recovery	<input type="checkbox"/>	<input type="checkbox"/>
Is 21 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>
Has 14 days of medication upon date of intake	<input type="checkbox"/>	<input type="checkbox"/>
If SUD, is able to safely function in a drug and alcohol-free environment	<input type="checkbox"/>	<input type="checkbox"/>
If diagnosed with a Mental/Behavioral Health illness, is stable and able to function safely in a congregate care residential setting without special accommodations	<input type="checkbox"/>	<input type="checkbox"/>

Exclusions: If yes to any of the following, then not eligible at this time

- 290PC registrant
- Active restraining order on current facility member receiving services
- Active drug/alcohol in need of detoxification services
- Recent violent assault upon a person
- Active suicide ideation and/or recent suicide attempt
- A danger to self and/or others
- Has an active contagious/infectious disease/illness

Some “ineligible” referrals due to the above list may be considered for CalAIM services depending on additional resources available and provided by the referring agency.



1. REFERRAL AGENCY INFORMATION

- Referring Facility/Agency Name: _____
 - Referring Contact Person: _____
 - Phone Number: _____
 - Email Address: _____
 - Date of Referral: _____
 - Anticipated Date of Placement: _____
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2. CLIENT INFORMATION

- Full Name: _____
 - Date of Birth: _____
 - Gender: Male Female Non-binary Other: _____
 - Preferred Language: _____
 - Medi-Cal ID Number: _____
 - Social Security Number (if available): _____
 - Phone Number (if available): _____
 - Emergency Contact: _____
 - Phone Number: _____
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3. MEDICAL STATUS

- Date of Hospital Discharge or Expected Discharge: _____
- Reason for Hospitalization: _____
- Current Medical Conditions (brief summary):

- Medical Needs During Stay (e.g., wound care, medication management):

- **Is the client ambulatory?** Yes No
 - **If No, How does the client navigate to meet Activities of Daily Living (ADLs) needs?** _____

 - **Requires assistance with ADLs ?** Yes No
 - What assistance is required? _____

 - **Mental Health Diagnosis (if applicable):** _____
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4. HOUSING STATUS

- **Current Living Situation:**
 - Homeless
 - Staying in shelter
 - Transitional housing
 - Other: _____
 - **Is the client willing to accept recuperative care services?** Yes No
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5. SUPPORT NEEDS

- **Duration of Needed Stay (estimate):** _____ days
 - **Follow-Up Appointments Scheduled:** Yes No
 - If yes, provide dates/locations: _____
 - _____
 - _____

 - **Transportation Needed/Assistance to Appointments?** Yes No
 - **Other Support Services Requested (check all that apply):**
 - Behavioral Health
 - Substance Use Support
 - Case Management
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- Housing Navigation
 - Other: _____
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6. DOCUMENTATION ATTACHED

- Hospital Discharge Summary
 - Medication List
 - Treatment Plan
 - Consent to Share Information
 - Other: _____
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7. REFERRAL DESTINATION

- Preferred Recuperative Care Facility (if known): _____
 - Has space been confirmed? Yes No
 - Estimated Admission Date: _____
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8. AUTHORIZATION

- Client has signed consent for referral and information sharing: Yes No
 - Name of Person Completing the Form: _____
 - Signature: _____
 - Date: _____
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Please provide any additional information that will support this referral:

Please send referral via one of the following dedicated methods:

- Email: referral@thecenternow.org
 - Phone: (530) 295-4201 (also reachable via our main line (530) 626-1450 ex. 201)
 - Fax (530) 295-4201
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