CS Personal Care and Homemaker Services
All Counties
Version 2

Personal Care and Homemaker Services Community Supports (CS) supports members who need assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs).

Submit completed form and supporting documentation to the UM Prior Authorization fax (833) 305-3130.

All fields with an * are required.

SECTION 1 – REFERRAL INFORMATION

Referral Date	
Referral Type	☐ Community Referral ☐ Identified by Molina ☐ Self-Referral ☐ Other:
Referring Organization Name	
Referring Organization NPI	
Referring Individual First Name*	
Referring Individual Last Name*	
Referring Individual Relationship to Member*	
Referring Individual Phone Number*	
Referring Individual Email Address*	

SECTION 2 – MEMBER INFORMATION

Member First Name*	
Member Last Name*	
Date of Birth*	
Medi-Cal CIN	
Preferred Written Language	
Member Email Address	
Member Primary Phone Number	
Member Residential Address	
City	
State	
Zip Code	

Is the member currently experiencing homelessness?	☐ Yes ☐ No ☐ Unknown

SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION

Member has Authorized Representative	☐ Yes ☐ No
Authorized Representative First Name	
Authorized Representative Last Name	
Authorized Representative Relationship to Member	
Phone Number	
Email Address	
Mailing Address	

SECTION 4 – CLINICAL INFORMATION

Primary Diagnosis	
ICD-10 Code	
Secondary Diagnoses	
Primary Care Provider	
Behavioral Health Provider (if applicable)	
Recent Hospitalization Within Past 30 Days	☐ Yes ☐ No
If Yes, Discharge Date	

SECTION 5 – SERVICE INFORMATION

Request Information

Service Start Date:

Service End Date:

Eligibility Criteria

Molina Enrollment:

☐ Enrolled in Medi-Cal with Molina

Member must meet one of the following:

☐ Member needs assistance with Activities of Daily Living (ADLs) and/or Instrumental Activity of Daily Living (IADL) tasks and has no other adequate support system.

OR

☐ Member is at risk for hospitalization or institutionalization in a nursing facility.

AND meet one of the following:

☐ Member was referred for IHSS and is searching for a caregiver through the Public Authority registry.

IHSS Referral Date: _____

OR

☐ Member currently receives IHSS and needs additional IHSS hours. The reassessment request is pending and a caregiver is needed for support in the meantime.

Reassessment Request Date: _____

IHSS Hours Per Month: _____

OR

☐ Member is not eligible for IHSS and needs services to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Provide the IHSS Notice of Action indicating denial if available.

Caregiver Support Preferences

Preferred Time for Caregiver Support: ☐ Morning ☐ Afternoon ☐ No Preference

Total Hours Requested: _____

Functional Needs Assessment

What are the member's physical limitations?

Activities of Daily Living (ADLs)

ADL	Independent	Needs Assistance	Dependent
Ambulation	☐	☐	☐
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Self-Feeding	☐	☐	☐
Toileting	☐	☐	☐
Transferring	☐	☐	☐

Continence Information

☐ Continent

☐ Incontinent of Bladder: ☐ Occasionally ☐ Frequently ☐ Always

☐ Incontinent of Bowel: ☐ Occasionally ☐ Frequently ☐ Always

☐ External/Internal Catheter

☐ Ostomy

☐ Other:

Medical Conditions:

What does the member need assistance with (bathing, cooking, housekeeping, shopping, meal preparation, etc.)?

Does the member have additional assistance from family or friends? ☐ Yes ☐ No

Does the member live alone? ☐ Yes ☐ No

Does the member have pets in the home? ☐ Yes ☐ No

Other Needs/Requests (i.e., Hoyer lift, male caregiver, language preference, etc.):

Special Instructions to Enter Residence:

Scheduling Contact

Scheduling Contact Name (if different from member/authorized representative):

Relationship to Member:

Phone Number:

SECTION 6 – REQUIRED DOCUMENTATION

Please attach all supporting documentation required for review.

☐ IHSS Referral Documentation (if applicable)

☐ IHSS Reassessment Request Documentation (if applicable)

☐ IHSS Notice of Action Denial (if applicable)

☐ Supporting Clinical Documentation

☐ Additional Supporting Documentation

SECTION 7 – ATTESTATION

Member Consent

☐ I attest that the member and/or authorized representative has consented to this Community Supports referral.

Referral Attestation

☐ I attest that the information provided in this referral is accurate and complete to the best of my knowledge.