CS Recuperative Care
All Counties
Version 2

Recuperative Care, also referred to as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an acute injury or illness (including a behavioral health condition). An individual need not be exiting an institution to qualify but must have been determined by a provider (at the MCP or Network Provider level) to have medical needs significant enough to result in ED visits, hospital admissions or other institutional care.

Recuperative Care services will be authorized for up to 30-day increments to support Global Cap requirements. Any continuation of services beyond the initial period must include updated justification and be submitted within 7 calendar days of the current authorization's end date.

If you are only requesting a change to an approved authorization, please email your request to MHC_CS@molinahealthcare.com. Examples of change requests include, but are not limited to: provider changes, service date changes, modifier corrections, etc.

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 Fax 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

Request Type: ☐ Initial Request ☐ Reauthorization Request **Existing Auth #:**

Service Start Date:

Service End Date:

Service Urgency: ☐ Urgent ☐ Routine ☐ Retro (not guaranteed approval)

If retro, please select reason and provide explanation:

Reason:

☐ Unable to verify member eligibility

☐ Failed fax – show evidence, must have called UM provider call center

☐ No response received – must call UM provider call center

Explanation:

Eligibility Criteria

Molina Enrollment:

☐ Enrolled in Medi-Cal with Molina

Members are eligible for Recuperative Care if they meet ALL of the following criteria:

☐ Medi-Cal member active with Molina

☐ Individual requiring recovery in order to heal from an injury or illness

☐ Experiencing or at risk of homelessness

Accepting Provider Information

☐ I confirm that an accepting Recuperative Care provider has been identified, bed availability has been confirmed, and the member meets eligibility criteria prior to submission.

Accepting Provider Name*:

Accepting Provider NPI*:

Accepting Provider Fax*:

Accepting Provider Phone*:

Accepting Provider Email*:

Please indicate the acute medical/behavioral health condition for which the member requires Recuperative Care services:

Recuperative Care Reason:

Patient Admit Date:

Patient Pending or Discharge Date:

Global Cap Information

There is a restriction of 182 days in any rolling 12-month period for all Room and Board services. This is known as the "Global Cap."

Room and board services include:

- Recuperative Care
- Short-Term Post Hospitalization Housing
- Transitional Rent

Number of Global Cap Days Already Used (if known):

Date of First Global Cap Service (if known):

Physical and Behavioral Health Information

Functional Status

Independent with ADLs/IADLs: ☐ Yes ☐ No

Bowel and Bladder Continent: ☐ Yes ☐ No

Self-Administers All Medications: ☐ Yes ☐ No

If no, describe:

Mobility

Mobility Status: ☐ Independent ☐ Modified Independent

If applicable, describe:

Assistive Device Required: ☐ Yes ☐ No

Screening Information

PPD/TB Test or Chest X-Ray Date:

Outcome:

COVID Test Date:

Outcome:

Wound Information

Wounds Present: ☐ Yes ☐ No

Number / Location / Size / Stage:

Post-Discharge Planning

Post-Discharge Treatment Plan:

Home Health Vendor:

Phone Number:

Behavioral Health / Cognitive Status

Check all that apply:

☐ Auditory/Visual Hallucinations

☐ Non-Compliant

☐ Forgetful

☐ Cognitive Impairment

☐ Registered Sex Offender

☐ Other

If checked, describe:

Ostomy / Catheter Information

Colostomy/Ileostomy: ☐ Yes ☐ No

Foley Catheter: ☐ Yes ☐ No

Independent with Catheter/Ostomy Care: ☐ Yes ☐ No

If no, describe:

Oxygen Requirements

O2 Required: ☐ Yes ☐ No

Concentrator: ☐ Yes ☐ No

If yes, describe including saturation:

Diabetes

Diabetic: ☐ Yes ☐ No

If yes, independent with: ☐ Insulin ☐ Glucose Checks ☐ Injectable Medications

Infection Control

Communicable Disease: ☐ Yes ☐ No

Needs Isolation: ☐ Yes ☐ No

If yes, describe:

Anticoagulation Monitoring

Prescribed Anticoagulants: ☐ Yes ☐ No

INR/PT/PTT Checks Required: ☐ Yes ☐ No

Follow-Up Appointments

Provider Name & Specialty	Phone Number	Appointment Date/Time	Reason	Address

SECTION 6 – REQUIRED DOCUMENTATION

Please attach all supporting documentation required for review.

☐ Comprehensive Medication List

☐ Face Sheet

☐ History & Physical (H&P)

☐ Psychiatric Notes (if applicable)

☐ Surgical Notes (if applicable)

☐ PT/OT Evaluation (if applicable)

☐ Social Work Notes (if applicable)

☐ 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.