



**CS Respite Services**  
**All Counties**  
**Version 4**

**Respite Services – Home Community Supports (CS)** are provided to caregivers when it is useful and necessary to maintain a member in their own home and to preempt caregiver burnout to avoid institutional services. The services are provided on a short-term basis because of the absence or need for relief for the caregiver and are non-medical in nature. This service is rest for the caregiver only and only to avoid Long-Term Care placements.

The combination of all services the member is receiving cannot exceed 24 hours per day of care.

**Send the completed referral via fax to: (833) 305-3130.**

**All fields with an \* are required.**

**SECTION 1 – REFERRAL INFORMATION**

<b>Referral Date</b>	
<b>Referral Type</b>	<input type="checkbox"/> Community Referral <input type="checkbox"/> Identified by Molina <input type="checkbox"/> Self-Referral <input type="checkbox"/> Other:
<b>Referring Organization Name</b>	
<b>Referring Organization NPI</b>	
<b>Referring Individual First Name*</b>	
<b>Referring Individual Last Name*</b>	
<b>Referring Individual Relationship to Member*</b>	
<b>Referring Individual Phone Number*</b>	
<b>Referring Individual Email Address*</b>	

**SECTION 2 – MEMBER INFORMATION**

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

<b>Is the member currently experiencing homelessness?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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**SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION**

<b>Member has Authorized Representative</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Authorized Representative First Name</b>	
<b>Authorized Representative Last Name</b>	
<b>Authorized Representative Relationship to Member</b>	
<b>Phone Number</b>	
<b>Email Address</b>	
<b>Mailing Address</b>	

**SECTION 4 – CLINICAL INFORMATION**

<b>Primary Diagnosis</b>	
<b>ICD-10 Code</b>	
<b>Secondary Diagnoses</b>	
<b>Primary Care Provider</b>	
<b>Behavioral Health Provider (if applicable)</b>	
<b>Recent Hospitalization Within Past 30 Days</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, Discharge Date</b>	

**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 pathways:****Adult Respite Eligibility****Member must meet BOTH:**

Member lives in the community and is compromised in Activities of Daily Living (ADLs), requiring dependency on a qualified caregiver.

Member's qualified caregiver, who provides most of the member's support, requires caregiver relief to avoid institutional placement for the member.

**OR****Pediatric Palliative Care Eligibility**

Member is a child who previously received Respite Services under the Pediatric Palliative Care Waiver.

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**Existing Caregiver Information**

**Is the member currently receiving In-Home Supportive Services (IHSS)?**  Yes  No

**If not currently receiving IHSS, has the member applied for IHSS?**  Yes  No

**Was IHSS applied for and denied?**  Yes  No

**Is the member ineligible for IHSS services?**  Yes  No

**If member has an existing IHSS caregiver, provide caregiver name and authorized hours:**

**Current Caregiver Name:**

**Current Caregiver Relationship to Member:**

**Proposed Respite Caregiver Name:**

**Proposed Respite Caregiver Relationship to Member:**

**Does the proposed respite caregiver currently live with the member?**  Yes  No

**Proposed Respite Start Date:**

**Proposed Respite End Date:**

**Caregiver Total Weekly Hours:**

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**Need for Respite Services**

Please describe the circumstances causing the need for Respite Services:

**Prior Respite Utilization**

Member previously received Respite Services during the current calendar year.

Is member receiving Respite Services through another program or vendor (e.g., Regional Center)?  Yes  No

Total Respite Hours Received to Date:

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**Member Care Needs**

Can the member administer their own medications?  Yes  No

Hospital Stay or Emergency Department Visit within the last 30 days?  Yes  No

Does the member have elopement or wandering behavior requiring continuous monitoring?  Yes  No

Does the member have difficulty chewing and/or swallowing?  Yes  No

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**Activities of Daily Living (ADLs)**

ADL	Independent	Needs Assistance	Dependent
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Current Assistive / Adaptive Devices**

- None
- Walker
- Wheelchair
- Cane
- Crutches

- Hearing Device
  - Dentures
  - Glasses or Other Vision Aids
  - Communication (AAC) Device
  - Specialized Eating Equipment / Utensils
  - Orthosis / Prosthesis
  - Gait Belt
  - Hoyer Lift
  - Respiratory Equipment
  - Other:
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**Continence Information**

- Continent
- Incontinent of Bladder:  Occasionally  Frequently  Always
- Incontinent of Bowel:  Occasionally  Frequently  Always
- External/Internal Catheter
- Ostomy
- Other:

**SECTION 6 – REQUIRED DOCUMENTATION**

Please attach all supporting documentation required for review.

- Clinical Documentation Supporting Medical Necessity
- Documentation Supporting ADL Dependency or Functional Limitations
- Hospital Discharge Summary (if applicable)
- Emergency Department Documentation (if applicable)
- IHSS Documentation (if applicable)
- IHSS Notice of Action (if applicable)
- Regional Center Documentation (if applicable)
- Documentation Supporting Caregiver Burden and Need for Respite Services

**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.

I attest that the member has not received more than 336 hours of Community Supports Respite Services during the current calendar year.