Recuperative Care and Short-Term Post-Hospitalization Referral Form

Recuperative Care is a short-term residential care for Members who no longer require hospitalization but still need to heal from an injury or illness and who's condition would be exacerbated by an unstable living environment. This form is intended to be used for IEHP Members only. Recuperative Care and Short-Term Post Hospitalization Housing

Request Type

☐ Initial Request ☐ Extension ☐ Bed Transfer ☐ Resumption of Care (Returning from a hospitalization)

Is the Member interested in participating in Community Supports? ☐ Yes ☐ No	**Placement Requested:** ☐ Recuperative Care ☐ Short-Term Post-Hospitalization Housing

Referring Contact Name/Title:	**Main Phone/Mobile #:**	**Email Address:**

Member's First Name:	**Last Name:**	**Member Mobile #:**	**IEHP ID:**

Diagnosis (Required):	**ICD Code:**

Community Supports Services Eligibility Criteria ***(check all that apply)***

Recuperative Care- must meet both of the following:

☐ Individuals requiring recovery in order to heal from an injury or illness.
Must be determined by a provider to have medical needs significant enough to result in ED visits, hospital admission or other institutional care AND
☐ Meet HUD Definition of Homelessness or at risk of homelessness.
Signed Homeless attestation by Member must be received as part of documentation required

Short-Term Post- Hospitalization Housing- must meet ALL the following:

☐ Members exiting an institution, recuperative care facility, inpatient hospitals (either acute or psychiatric or Chemical Dependency and recovery hospital), residential substance use disorder or mental health treatment facility, correctional facility, or nursing facility
☐ Meet HUD definition of Homelessness or at risk of homelessness
☐ Meet one of the following criteria:
- ☐ Are receiving Enhanced Care Management
- ☐ Have one or more serious chronic condition
- ☐ Have serious mental illness
- ☐ Are at risk of institutionalization or requiring residential services as a result of a substance use disorder

☐ Have ongoing physical or behavioral health needs as determined by a qualified health processional that would otherwise require continued institutional care if not for receipt of Short-Term Post- Hospitalization Housing

Recuperative Care and Short-Term Post-Hospitalization Housing combined cannot exceed a duration of six months per rolling 12-months.

Please note, if box is NOT checked, STOP. Member does not meet eligibility criteria. Please submit supporting documentation with the referral form.

Current Housing Status	**Current Region**	**Placement Location**
☐ Prioritized for permanent supportive Housing unit/rental subsid resource through the local homeless Coordinated Entr System or similar system ☐ Meets HUD definition of "homelessness" ☐ At risk of experiencing homelessness	☐ San Bernardino Proper ☐ West San Bernardino ☐ High Desert ☐ Low Desert ☐ Corona/Temecula/Hemet ☐ Riverside ☐ Other: _____	Willing to be housed in another County: ☐ Yes ☐ No Willing to be housed in anywhere in current County: ☐ Yes ☐ No Willing to be housed in current city only: ☐ Yes ☐ No Previously in another housing program: ☐ Yes ☐ No Area(s) Member CANNOT live in:

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Serious Chronic Condition (check all that apply):	**Serious Mental Illness** ***(check all that apply):***	**Substance Use Disorder** ***(check all that apply):***
☐ Diabetes requiring insulin ☐ Uncontrolled Hypertension ☐ Congestive Heart Failure ☐ End-Stage Renal Disease ☐ Cancer requiring radiation or chemotherapy ☐ Other: ***NOTE: Please include supporting documentation outlining how Member is unstable and requires recuperative care.***	☐ Bipolar Disorder ☐ Schizophrenia ☐ Major Depressive Disorder ☐ Post-Traumatic Stress Disorder (PTSD) ☐ Obsessive Compulsive Disorder (OCD) ☐ Borderline Personality Disorder ☐ Other: ***NOTE: Please include supporting documentation outlining active signs and/or symptoms Member is displaying.***	☐ Alcohol ☐ Opioid Abuse ☐ Heroine ☐ Cocaine ☐ Methamphetamines ☐ Other: ***NOTE: Please include positive drug screen if available.***

Health Information

Does Member have impaired cognition? ☐ Yes ☐ No

Is Member able to ambulate at least 250ft with or without assistance?
☐ Yes ☐ No

Does Member use a wheelchair, walker, cane, etc. and if so, is Member independent?
☐ Yes ☐ No

Is Member independent with transfers?	☐ Yes	☐ No
Can Member self-administer all medications independently?	☐ Yes	☐ No
Is Member continent of both bowel and bladder?	☐ Yes	☐ No
Does Member take any medications requiring refrigeration?	☐ Yes	☐ No
Does Member require oxygen?	☐ Yes	☐ No
Does Member require ostomy care and or catheter care?	☐ Yes	☐ No
Does Member require a wound vac, Bipap, and/or Cpap?	☐ Yes	☐ No
Does Member require wound care?	☐ Yes	☐ No
Can Member perform wound care independently?	☐ Yes	☐ No
Does Member require IV antibiotics?	☐ Yes	☐ No
Can Member administer IV antibiotics independently?	☐ Yes	☐ No

NOTE: Please provide supporting documentation. If Member cannot perform wound care or administer IV antibiotics independently, Home Health arrangements must be arranged prior to admission to recuperative care.

Animals/Pets

Is Member requesting to bring an animal? ☐ Yes ☐ No

Is animal a service animal or emotional support animal?

☐ Service animal
☐ Emotional support animal
☐ Neither

Describe the type and number of animal(s):

Medical Clearance

Is Member medically stable for discharge?	☐ Yes	☐ No
Has Member been cleared for communicable diseases?	☐ Yes	☐ No
Is Member psychiatrically stable for discharge?	☐ Yes	☐ No
Is Member independent with ADLs?	☐ Yes	☐ No

Note: If 'No' box is checked, STOP. Member does not meet eligibility criteria.

Additional Needs: ***(check all that apply)***

☐ Requires Anticoagulants
☐ Requires Injectable Medications
☐ Requires INR/PT/PTT checks
☐ Other:

Please attach the documents listed below, if available. Be sure to provide supporting documentation for areas listed above.

1. **UM Referral Form**
2. **Facesheet**
3. **History and Physical**
4. **Medication List**
5. **Wound Care Notes, if applicable**
6. **Psych Notes, if applicable**
7. **Labs/Tests/Vital Signs**
8. **Chart Notes**
9. **Supporting documents such as Social Worker Notes, Nurse Progress Notes, Paramedic Notes, etc.**

This Request Does Not Guarantee Eligibility. Check Eligibility Prior to Rending Service.
Payment Will Not Be Made For Unauthorized Services.