

RECUPERATIVE CARE REFERRAL FORM

Recuperative care (medical respite care) is short-term post-hospital residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. For more information, review the [Authorization Guide for Recuperative Care](#) available on provider.healthnetcalifornia.com > CalAIM Resources for Providers > Forms & Tools > Authorizations.

Complete and submit this referral form with the [Medi-Cal – Prior Authorization Request Form – Outpatient](#) online (recommended) at provider.healthnetcalifornia.com or by fax at 800-743-1655.

Select one:	<input type="checkbox"/> Initial request	<input type="checkbox"/> Extension request	<input type="checkbox"/> Transfer
Confirm member consent/attestation:	<input type="checkbox"/> Member consented to recuperative care referral <input type="checkbox"/> Member attests to need for housing and housing navigation services		
Member Information			
Member name:		Phone number:	
Medi-Cal ID:	Date of birth:	Preferred language:	
Home address:			
Contact name (if different than member):		Phone number:	
Relationship:		Preferred language:	
(Optional) Member's ECM Provider name:		Phone number:	
Explain member's need for recuperative care (initial, extension or transfer request). Note: Member's stay cannot exceed more than 90 days in continuous duration.			
Community Supports Provider Information (Servicing Organization)			
Organization name:			
Tax ID:	National provider identifier (NPI):		
Staff name:	Title:		
Phone number:	Fax number:		
Eligibility Criteria			
Select all that apply.			
<input type="checkbox"/> Member is at risk of hospitalization.			
<input type="checkbox"/> Member lives alone with no formal supports.			
<input type="checkbox"/> Member faces housing insecurity or has housing that would jeopardize their health and safety without modification.			
Required Documents			
Submit documents with the referral form.			
<input type="checkbox"/> Admission face sheet	<u>OR</u>	<input type="checkbox"/> Discharge summary from previous institution	<u>OR</u>
<input type="checkbox"/> History and physical			<input type="checkbox"/> Street medicine provider assessment