Department of Human Services
Med-QUEST Division

Community Integration Services Plus (CIS+)
Medical Respite Authorization Form
(Appendix I)

This form supports Medical Respite service authorization activities. A Qualified Health Professional (Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], Nurse Practitioner [NP], or Physician Assistant [PA]) must review, approve, and sign every submission and may use support staff to complete the form. For each submission, check the Review Type in Part 1 and complete the parts shown in the table below. Fax the completed form to the member's Health Plan using the contact information at the end of this form. Attach supporting clinical documentation to every Extension Request and to any submission in which a Qualified Health Professional affiliated with the Medical Respite Provider changes the member's level of care from MQD Level 1/2 to MQD Level 3/4. For all other submissions, attaching the supporting documentation is recommended to avoid delays.

Initial Authorization: Submit this form to request initial authorization for new Medical Respite services.

Extension Request: Submit this form to request an extension of Medical Respite services when the member needs Medical Respite beyond the initial authorized period.

Ongoing Clinical Appropriateness Verification: Submit this form no later than 30 days following the member's admission to Medical Respite and every 30 days thereafter for the duration of the member's stay to verify that Medical Respite remains clinically appropriate for the member.

Submission	Parts to complete	Who may sign	Frequency of use
Initial Authorization (New/initial Medical Respite admission)	Parts 1 through 7	A Qualified Health Professional free from conflicts of interest with the Medical Respite Provider (NOT affiliated with the Medical Respite Provider)	Once per new Medical Respite stay
Extension Request	Parts 1 through 3 and Part 7	Any Qualified Health Professional (may include one affiliated with the Medical Respite Provider; a Health Plan clinical reviewer must confirm any change from MQD Level 1/2 to MQD Level 3/4 made by an affiliated professional)	As needed, when the member needs Medical Respite beyond the authorized period
Ongoing Clinical Appropriateness Verification (stays longer than 30 days)	Parts 1 through 3 and Part 7	Any Qualified Health Professional (may include one affiliated with the Medical Respite Provider; a Health Plan clinical reviewer must confirm any change from MQD Level 1/2 to MQD Level 3/4 made by an affiliated professional)	No later than 30 days after admission and every 30 days thereafter

PART 1: CLINICIAN REFERRAL SOURCE AND TYPE

Review Type (check all that apply):
☐ Initial Authorization ☐ Extension Request ☐ Ongoing Clinical Appropriateness Verification

Signing Clinician Information	*Coordinator, if different from the signing clinician*
Clinician Name:	Coordinator Name:
Clinician NPI:	Coordinator Email:
Clinician Relationship to Member:	Coordinator Phone Number:
Clinician Phone Number:	
Clinician Email:	
Clinician Fax:	

Is the signing clinician employed by or financially affiliated with the Medical Respite Provider?
☐ No ☐ Yes

PART 2: MEMBER INFORMATION				
First Name:	Last Name:		Middle Initial:	
Date of Birth:	HMIS #, if known:		Medicaid ID #:	
Community Care Services (CCS)? ☐ Yes ☐ No	Sex ☐ Male ☐ Female ☐ Prefer not to respond	Veteran? ☐ Yes ☐ No	Height:	Weight:
Current Location/Address:		City, State, Zip Code:		
Mailing Address (if available and different from above):		City, State, Zip Code:		
Phone Number:		Email Address:		
Any friends or family who can help reach the member? ☐ No ☐ Yes, Name/Phone:				
Does the member have interpretation needs? ☐ No ☐ Yes, Language:				

PART 3: SERVICES NEEDED

Which Medical Respite service do you recommend for the member?

☐ Short-Term Pre-Procedure Housing: *For members in need of housing who have a planned medical procedure requiring preparatory care or a medical treatment requiring care prior to or following treatment. The maximum service length is determined by clinical appropriateness. Pre-procedure/treatment Medical Respite stays should be no longer than seven (7) days and post-procedure/treatment stays should be no longer than three (3) days*.

1. Procedure:
2. Date of Procedure:
3. Reason for Procedure (include ICD-10 code(s)):

☐ Short-Term Recuperative Care: *For members in need of housing with clinically oriented recuperative or rehabilitative services or supports, and monitoring of ongoing medical and psychiatric needs. The maximum service length is determined by clinical appropriateness, not to exceed 90 days. Short-Term Recuperative Care allows referrals from institutions and other referral sources (e.g., community provider, street medicine team, emergency department).*

1. Which medical and/or behavioral health diagnoses does the member have that would otherwise require continued care in an institution if not for receipt of Medical Respite services (include ICD-10 code(s))?

2. What physical or behavioral health needs does the member have that would otherwise require care in an institution?

3. Is the member currently admitted to an institutional setting?
   ☐ Yes ☐ No

If yes (the member is admitted to an institutional setting)

3a. Date of initial institution admission:
3b. Reason for initial institution admission:
3c. Tentative institution discharge date (if available):

3d. Institution type:

☐ Acute care hospital
☐ Nursing facility
☐ Inpatient psychiatric facility
☐ Other institutional setting: _____

If no (The member is <u>not</u> admitted to an institutional setting):

3e. If Medical Respite were not available, which setting would this member most likely require? (check one):

☐ Acute care hospital
☐ Nursing facility
☐ Inpatient psychiatric facility
☐ Other institutional setting: _____

4. Clinical Attestation: I attest that, based on my clinical judgment, this member has medical and/or behavioral health needs that require, or would likely require, ongoing care in a hospital or other institutional setting if Medical Respite services are not available as an alternative placement. The information in this form should support this determination.

   ☐ Yes (required)

☐ <u>Short-Term Post-Hospitalization Housing:</u> *For members in need of housing and limited support to continue recovery from a physical, psychiatric, and/or substance use condition, following discharge or exit from an institution. The maximum service length is determined by clinical appropriateness, not to exceed six (6) months of Medical Respite benefits per rolling 12-month period.*

1. Which medical and/or behavioral health diagnoses does the member have that would otherwise require continued care in an institution if not for receipt of Medical Respite services (include ICD-10 code(s))?
2. What physical or behavioral health needs does the member have that would otherwise require care in an institution?
3. Date of initial institution admission:
4. Reason for initial institution admission:
5. Tentative institution discharge date (if available):
6. Institution type (Institutional care settings do not include the emergency department):

   ☐ Acute care hospital
   ☐ Nursing facility
   ☐ Inpatient psychiatric facility
   ☐ Other institutional setting: _____

Medical Respite Provider and Site Name:

Medical Respite admission date (if the member has already been admitted):

Recommended Medical Respite length of stay:

Recommended Medical Respite stay extension (if applicable)

- Current authorized discharge date:
- Recommended Medical Respite discharge date:

Which social eligibility criteria does the member meet?

☐ Experiencing homelessness ☐ At risk of experiencing homelessness

Attach evidence of homelessness, or risk of homelessness, if known.

Does the member also need Housing Navigation services?

☐ Yes ☐ No

PART 4: MEDICAL CONDITION	
Did the member have a positive Purified Protein Derivative (PPD) test? ☐ No ☐ Yes If yes, date PPD read:	Did the member have a chest x-ray? ☐ No ☐ Yes If yes, Chest x-ray Date: If yes, Chest x-ray: ☐ Positive ☐ Negative
Does the member require medical follow-up? ☐ No ☐ Yes If yes, please describe:	
Is the member able to self-administer and monitor own medication? ☐ No ☐ Yes	
Does the member adhere to all aspects of medical care? ☐ No ☐ Yes If no, please describe:	
Does the member have an intact immune system? ☐ No ☐ Yes If no, please describe:	
Does the member have a history of known communicable diseases? ☐ No ☐ Yes If yes, list and include date of last episode:	
Does the member have external appliances (durable medical equipment or medical devices)? ☐ No ☐ Yes	
Does the member have special diet requirements? ☐ No ☐ Yes If yes, list:	
Does the member have any medication allergies? ☐ No ☐ Yes, if yes, list:	
Are vaccination records available for this member? ☐ No ☐ Yes	
Please list current medications:	
Other comments:	
PART 5: BEHAVIORAL HEALTH / CHEMICAL DEPENDENCY STATUS	
Is the member alert and oriented to time and place? ☐ No ☐ Yes	
Does the member have memory loss? ☐ None ☐ Short-term ☐ Long-term ☐ Both	
Mental health history:	

If applicable, mental health case manager name and contact information:

Does the member have a history of violent behavior?
☐ No ☐ Yes
If yes, please describe with reason and include date of last episode:

Does the member have a history of suicidal behavior?
☐ No ☐ Yes
If yes, describe and include date of last episode:

Does the member have a history of substance use/chemical dependency?
☐ No ☐ Yes
If yes, list substance(s) and last use:

Preferred substance:

Interested in treatment? ☐ No ☐ Yes

Drug screen results? ☐ Positive, Date of test:_____ ☐ Negative, Date of test: _____
☐ Drug screening not complete

History of smoking? ☐ No ☐ Yes

History of Traumatic Brain Injury (TBI)?
☐ No ☐ Yes
If yes, describe:

PART 6: MEMBER'S ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING (ADLs) WITHOUT ASSISTANCE

Able to walk at least 30 feet? ☐ No ☐ Yes	Able to prepare simple meals independently? ☐ No ☐ Yes
Able to navigate stairs? ☐ No ☐ Yes	Able to feed self? ☐ No ☐ Yes
Uses ambulatory aids? ☐ No ☐ Yes If yes, describe: If yes, able to transfer independently? ☐ No ☐ Yes	Continent of bowel: ☐ No ☐ Yes Continent of bladder: ☐ No ☐ Yes Able to toilet self? ☐ No ☐ Yes
Able to maintain good hygiene? ☐ No ☐ Yes	Able to bathe self? ☐ No ☐ Yes

Any communication barrier (e.g., language, hard of hearing)?
☐ No ☐ Yes, if yes, describe:

PART 7: MEMBER LEVEL OF CARE DETERMINATION
Instructions: Answer Questions 1 and 2 for every member. Question 1 documents whether the member requires lower intensity services and supports under the MQD Level 1/2 Care Model or higher intensity services and supports under the MQD Level 3/4 Care Model. Use Question 2 to explain the member's needs. Select MQD Level 1/2 for any member who does not meet the MQD Level 3/4 description but otherwise qualifies for Medical Respite.
1. Based on my clinical judgment and review of supporting documentation, this member has medical and/or behavioral health needs that require Medical Respite at the following level of care (check only one response): ☐ **MQD Level 1/2 (Lower Intensity Care Model):** The member self-manages medications or needs medication management by licensed clinical staff and monitors their condition with staff support. Community-based providers can meet the member's medical needs, with basic onsite services if needed, such as vital signs and condition monitoring, health education, and medication review. ☐ **MQD Level 3/4 (Higher Intensity Care Model):** The member needs onsite clinical care (licensed practical nurse [LPN] or higher) on every shift during the stay, including evaluation by a prescribing provider within their scope of practice at least weekly, more often when the care plan calls for it, and within 24 hours of a reported change in condition, onsite or by telehealth.
2. Explain the member's clinical needs that support the level of care selected in Question 1, including any context not captured elsewhere in this form. **REMINDER: Attach supporting clinical documentation to every Extension Request and to any change from MQD Level 1/2 to MQD Level 3/4 made by a Qualified Health Professional affiliated with the Medical Respite Provider. For other submissions, attaching documentation helps avoid delays.**

Clinician Signature: _____

Date: _____

CIS+ Medical Respite Authorization Form Instructions

Please fax this document to the member's Health Plan with ATTN: Medical Respite Authorization Form**.**

AlohaCare	**HMSA**	**Kaiser Permanente**	**UnitedHealthcare**	**CCS**
Fax: 808-973-0676	Fax: 808-948-8243	Fax: 855-416-0995	Fax: 800-267-8328	Fax: 855-637-2941