Department of Human Services
Med-QUEST Division

Community Integration Services Plus (CIS+) – Referral

(Appendix B)

PART 1: REFERRAL SOURCE			
1. Who is referring this member to CIS+?			
☐ Self	☐ Family/Friend	☐ Internal Referral	☐ Another Health Plan
☐ Correctional Facility	☐ Medical Provider	☐ Nursing Facility	☐ Social/Housing Services Provider
☐ Hospital	☐ Other Referral Source (specify): _____		
2. Referrer Name:		3. Referring Agency (if applicable):	
4. Referral Date:		5. Contact Phone Number:	
6. Contact Fax Number:		7. Contact E-Mail Address:	

PART 2: SERVICES NEEDED	
8. What service(s) does the member need? (Subject to eligibility and member consent)	
Housing Navigation Supports (HNS): ☐ Pre-Tenancy Supports ☐ Tenancy Sustaining Services	*Medical Respite (MR):* ☐ Short-term Pre-Procedure Housing ☐ Short-term Recuperative Care ☐ Short-Term Post-Hospitalization Housing

PART 3: MEMBER INFORMATION		
9. Member First Name:	10. Member Last Name:	11. MI:
12. Date of Birth: _____/_____/_____	13. Member HMIS #:	14. Medicaid ID #:
15. CCS? ☐ No ☐ Yes	16. Health Plan: ☐ HMSA ☐ Kaiser ☐ AlohaCare ☐ Ohana ☐ United	
17. Current Location/Address:	18. City, State, Zip Code:	
19. Mailing Address (if different from above):	20. City, State, Zip Code:	
21. Best Contact Phone Number:	22. Best Contact Email Address:	
23. Any friends or family who can help reach member? ☐ No ☐ Yes, Name/Phone:		
24. Does the member have interpretation needs? ☐ No ☐ Yes, Language:		

PART 4: PRESUMPTIVE MEMBER ELIGIBILITY INFORMATION (Subject to Verification)	
A member is eligible for CIS+ if they have <u>both</u> a housing risk factor and either a health or medical respite need. **ATTACH EVIDENCE OF CHECKED OFF HEALTH NEEDS and RISK FACTORS if known**	
PART A: HEALTH NEEDS-BASED CRITERIA	**PART B: HOUSING CRITERIA**
☐ Mental Health ☐ Complex Physical Health ☐ Substance Use	☐ Homelessness, if checked (☐ Sheltered/☐ Unsheltered) ☐ At risk of homelessness
PART C: MEDICAL RESPITE (IF APPLICABLE) (Include Medical Respite Authorization Form if medical provider)	
☐ At risk of hospitalization, institutionalization, or emergency department utilization ☐ In an institution (e.g., inpatient hospital, nursing facility) ☐ Have a planned medical procedure requiring care prior to or following the procedure	

CIS+ Referral Form Instructions

Please fax this referral to the appropriate Health Plan with ATTN: QI CIS+ Program

AlohaCare Fax	**HMSA** Fax	**Kaiser** Fax	**Ohana** Fax	**United** Fax	**CCS** Fax
HNS/MR: 808-973-0676	HNS/MR: 808-948-8243	HNS/MR: 855-416-0995	HNS: 855-703-8078 MR: 855-637-2941	HNS/MR: 800-267-8328	HNS: 855-703-8078 MR: 855-637-2941

If you do not know the member's Health Plan, please fax to Med-QUEST at 808-692-8087.