Department of Human Services
Med-QUEST Division

Community Integration Services Plus (CIS+) – Assessment

(Initial/Re-enrollment – Appendix D)

Part I: Agency Information

CIS+ Provider Agency:	Medicaid Provider ID:	
Interviewer Name & ID (If applicable):	Date Assessment Initiated:	Date Assessment Completed:

Part II: Member Information

Member First Name:		Member Last Name:		Middle Initial:
Medicaid ID#:		Birthdate:		Age (Years):
HMIS ID# ☐ Unknown ☐ Not in HMIS	Medicaid Redetermination Date:	Other Relevant IDs (VA, etc.) (specify):		Other ID Number(s):
Current Residential Address/Location				
Street or Location:		City:		Zip Code:
Mailing Address (if different from current address)				
Street:		City and State:		Zip Code:
Contact Information	Phone Number	Can receive texts?	Email Address:	
	1.	Yes ☐ No ☐		
	2.	Yes ☐ No ☐		
Any friends or family who can help reach you? Yes ☐ No ☐ If yes, Contact Name:			Contact Phone Number:	Relationship to Member:

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Income		
Anticipated Total Monthly Income $	Anticipated Amount Available for Rent $	Is participant eligible for or receiving SSI? □ Yes □ No
Is Member receiving TANF? ☐ Yes ☐ No	Do you have a Legal Guardian/Power of Attorney/Rep Payee to assist in decision making? ☐Yes ☐ No If yes, person's name and contact information:	
Household Composition		
Number of additional household members: Adults _____ Children _____	Does participant require a live in caregiver? □ Yes □ No	Does participant want a roommate? □ Yes □ No □ Maybe

Homeless Status	Medical Respite Need
□ At-risk of homelessness □ Homeless for less than 1 continuous year □ Multiple times homeless but not chronically* homeless □ Chronically homeless **Chronically homeless: homeless for 1 continuous year or more or 4 times homeless in last 3 years (that add up to 1 year)*	Participant has a clinical need for: □ Short-term pre-procedure housing □ Short-term recuperative care □ Short-term post-hospitalization housing □ No medical respite need

Transportation
Participant has a car □ Yes □ No
Participant has TheHandi-Van, Paratransit Services, or TheBus pass □ Yes □ No
Participant has other transportation options □ Yes □ No If yes, please specify:
Veteran Status
Has participant ever served on active duty in US Armed Forces? □ Yes □ No
Housing Barriers
Rental History □ Poor rental history □ Rental history with no issues □ No rental history
Credit History □ Poor credit history □ Credit history with no issues □ No credit history
Criminal History □ Has criminal history □ Criminal history with no issues □ No criminal history
Eviction History □ Has Eviction history □ Eviction history with no issues □ No eviction history
Has participant applied for a Housing Choice Voucher (Section 8)? □ Yes □ No
Has participant applied for Public Housing? □ Yes □ No
List any other housing that participant has applied for:

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(Initial/Re-enrollment – Appendix D)

What were the primary reasons that caused you to experience homelessness (last occurrence if multiple) or have placed you at risk of homelessness?

Mental Health or Substance Use Disorder		*Physical Health Condition or Disability*		*Stress and Violence*		*Economic Reasons*	
☐	Alcohol or drug use	☐	Illness or medical problem	☐	Divorce/separation	☐	Loss of public housing or section 8 voucher
☐	Left a substance abuse treatment program and had nowhere to go	☐	Released from a hospital with nowhere to go	☐	Death in the family or death of a loved one	☐	Loss due to foreclosure including eviction from a foreclosed rental property
☐	Mental illness	☐	Disabled	☐	Family or domestic violence	☐	Evicted from a foreclosed rental property
☐	Other reasons exacerbated by mental health disorders or substance abuse	☐	Other reasons exacerbated by physical health conditions or disabilities	☐	Argument with family or friends	☐	Released from jail or prison and had nowhere to go
		☐	COVID-19 related	☐	Loss of housing due to non-economic reasons (house fire, lease violation, etc.)	☐	Unable to pay rent
				☐	Relocation or transition from another state	☐	Unable to pay mortgage
						☐	Lost job
						☐	SSI or SSD cut off or benefits canceled

Other reasons:

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Community Integration Services Plus (CIS+) – Assessment

(Initial/Re-enrollment – Appendix D)

Part III: Preferences

Living Arrangements				
□ Supervised Group Home □ Shared Apartment or Home □ Single Occupancy Apartment □ Group home (i.e. foster home) □ Independent rental □ Living with family/friends □ Medical Respite (i.e. clinically supportive living environment)				
How many bedrooms does the participant want (excludes medical respite)? □ Studio □ 1 bedroom □ 2 bedrooms □ 3 bedrooms □ 4 bedrooms				
□ Oahu	○ Honolulu	○ Windward	○ Central	○ Leeward
□ Hawaii	○ East	○ West	○ North	
□ Kauai				
□ Maui	○ Kahului	○ Kihei	○ Lahaina	
□ Molokai				
□ Lanai				
What specific areas does the person want to live? _____				
Does household have any pets? □ Yes □ No If yes, type and # of pets:				

Accessibility Needs
□ No physical accessibility needs □ No stairs/ground floor □ Doorways at least 32 inches wide □ Front knob on appliances □ Roll in shower □ Grab bars in bath □ Lever door handles □ Other (please specify):

Other Preferences							
Air conditioning	□ High	□ Medium	□ Low	□ None	Parking available	□ High □ Medium □ Low □ None	
Community area	□ High	□ Medium	□ Low	□ None	Pet friendly	□ High □ Medium □ Low □ None	
Exercise room	□ High	□ Medium	□ Low	□ None	Public Transportation	□ High □ Medium □ Low □ None	
Laundry on-site	□ High	□ Medium	□ Low	□ None	Smoking allowed	□ High □ Medium □ Low □ None	
Other (please specify)							

Part IV: Housing Readiness

Housing Documents
Participant has access to the following housing documents: Government issued picture identification □ Yes □ No Social security card □ Yes □ No Birth certificate □ Yes □ No Proof of income letter from Social Security □ Yes □ No Current bank statements □ Yes □ No Other income and asset information □ Yes □ No □ Not applicable
When will participant be ready for housing? □ Immediately □ Within 3 months □ Within 6 months □ Within a year □ A year or more □ Other (please specify):

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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Part I: Agency Information

CIS+ Provider Agency:	Medicaid Provider ID:	
Interviewer Name & ID (If applicable):	Date Initiated:	Date Completed:

Part II: Member Information

Member First Name:		Member Last Name:		Middle Initial:
Medicaid ID#:		Birthdate:		Age (Years):
HMIS ID# ☐ Unknown ☐ Not in HMIS		Medicaid Redetermination Date:	Other Relevant IDs (VA, etc.) (specify):	Other ID Number(s):
Current Residential Address/Location				
Street or Location:		City:		Zip Code:
Mailing Address (if different from current address)				
Street:		City and State:		Zip Code:
Contact Information	Phone Number	Can receive texts?	Email Address:	
	1.	Yes ☐ No ☐		
	2.	Yes ☐ No ☐		
Any friends or family who can help reach you? Yes ☐ No ☐ If yes, Contact Name:			Contact Phone Number:	Relationship to Member:

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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Read to member: I am going to ask you some questions about your health, well-being, housing history, and access to resources. This information will help us understand what is important to you and find out which services best suit your needs. You do not have to answer a question if you don't want to.

Part III: Member Health and Well-being

1. Would you say that in general your health is:	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?				Number of Days _____	
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?				Number of Days _____	
4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?				Number of Days _____	

Part IV: Member Housing

5. In the last 30 days, how many days have you lived: (enter number of days)	Outside (e.g., street, car, camper/RV or park) _____ days	at an emergency shelter _____ days	at a temp/transitional shelter _____ days	in a supervised group home _____ days	in a shared apartment _____ days	in an independent apartment _____ days
6. Do you have any new accessibility needs?	☐ Yes*	☐ No	*6a. If yes, what are your accessibility needs?			
7. Are you currently housed?	☐ Yes. If **yes**: 7a. What type of housing: ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Other 7b. Are you newly housed since the last assessment: ☐ Yes ☐ No			☐ No. If **no**: 7c. Have you lost housing since last assessment: ☐ Yes ☐ No		
8. **Tenancy Only:** Are you satisfied with your current housing?	☐ Yes	☐ No*	*8a. If no, what are your concerns?			

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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Part V: Services/Resource Utilization

Services/Resources	USED this service (past 30 days)	NEED this service	Not interested in this service
Financial			
1. Financial help for rent/rent subsidies, utilities, or other one-time costs	☐	☐	☐
2. Budgeting assistance/money management; establishing credit; financial counseling	☐	☐	☐
Housing			
3. Housing documents; ID assistance	☐	☐	☐
4. Rental housing information; applications; interviews; appeals; CES	☐	☐	☐
5. Finding accessible/affordable housing that meets my/my family's needs	☐	☐	☐
6. CIS+ short-term pre-procedure housing (for a planned procedure/treatment)	☐	☐	☐
7. CIS+ short-term recuperative care (up to 90 days)	☐	☐	☐
8. CIS+ short-term post-hospitalization housing (up to 6 months)	☐	☐	☐
9. Emergency shelter/temp housing/transitional housing	☐	☐	☐
10. Permanent housing	☐	☐	☐
11. Landlord mediation	☐	☐	☐
12. Development of/changes to eviction prevention plan	☐	☐	☐
13. Ongoing housing subsides	☐	☐	☐
Healthcare			
14. Accessing medical services; vision; nutrition/dietitian, dental; primary care	☐	☐	☐
15. Accessing mental health services and social supports; crisis services	☐	☐	☐
16. Substance abuse treatment services	☐	☐	☐
17. Compliance with Medical/Mental Health/Substance Use Plan of Care and medications	☐	☐	☐
Health Coordination			
18. Health Coordination by Health Plan *If member needs or refuses health coordination, refer to health plan for review*	☐	☐	☐

Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Social Services			
19. Securing/maintaining Medicaid eligibility	☐	☐	☐
20. Benefits services, including TANF, SSI and SSDI	☐	☐	☐
21. Accessing food benefits, including WIC and SNAP	☐	☐	☐
22. Accessing food/necessities; soup kitchen or food pantry; cooking	☐	☐	☐
23. Legal assistance; probation; parole	☐	☐	☐
24. Clothes closet	☐	☐	☐
25. Day center with telephones, mailrooms, or restrooms	☐	☐	☐
Employment Assistance			
26. Job readiness, job search, or employment assistance, vocational services; education, volunteer supports	☐	☐	☐
Transportation			
27. Transportation assistance	☐	☐	☐
Other Services/Resources			
28. Individual and/or family counseling, skills coaching; support groups, natural supports, anger management/domestic violence/AA-NA	☐	☐	☐
29. Caregiving for children and other relatives	☐	☐	☐
30. End of life planning	☐	☐	☐
31. Personal Care (long-term support services)	☐	☐	☐

Part VI: Person-Centered Housing Goals

32. What are your **housing** goals (short-term and long-term)? **(Complete during initial assessment. Review and revise as needed quarterly)**
a.
b.
c.
d.

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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Part VII: Other Interviewer Notes and Observations:

33. Person-centered plan meeting or revision plan meeting held with member: ☐ Yes ☐ No
34. CIS+ assessment completed: ☐ Yes ☐ No
35. Notes:

Part VIII: Discharge from CIS+:

36. Is member exiting CIS+?	☐ Yes*	☐ No	*If yes, what type of housing is the member exiting to/remaining in? ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Place not meant for habitation (e.g., car, beach, street, park, etc.) ☐ Other (Deceased, Relocated out of state)_____ Date of Discharge *(mm/dd/yy)*:

Signatures
This information was collected in good faith and is as accurate as possible:

Member Signature	Member Advocate Signature (if applicable)	Date
CIS+ Interviewer Signature	CIS+ Interviewer Name & Title	Date

Detailed CIS+ Process

Identifying Beneficiaries

HP identifies potentially eligible beneficiary

HP receives CIS+ Referral Form through fax

HP receives self/community referrals through other communication channels

HP updates CIS+ Status Code to (H1)

Key

Decision

Action

Service Receipt

Service End

QI HP – QI Health Plan
CCS – Community Care Services Program for Behavioral Health
HP – Any Medicaid HP, QI or CCS

Determining Eligibility

Based on referral information, HP completes eligibility screening

Member needs Housing Navigation Supports only

Member needs Medical Respite only

Member needs Medical Respite and Housing Navigation Supports

Scenario 1: HP has sufficient information to determine eligibility

Scenario 2: Member engagement is needed; HP meets with Member to complete eligibility screening

Scenario 3: Provider engagement is needed; HP authorizes 1-3 months of provider engagement (T1023) and updates CIS+ Status Code to (HA)

Provider meets with Member to determine eligibility

Scenario 4: HP checks eligibility for **short-term recuperative care.** A qualified health professional must submit a Medical Respite Authorization Form.

Scenario 5: HP checks eligibility for **short-term post-hospitalization housing.** A qualified health professional must submit a Medical Respite Authorization Form.

Scenario 6: HP checks for eligibility for **short-term pre-procedure housing** and (optional) verifies complex behavioral/physical need for housing navigation supports eligibility. A qualified health professional must submit a Medical Respite Authorization Form.

HP makes eligibility determination

HP makes eligibility determination

HP makes eligibility determination

Result 3: Potentially eligible but unable to contact (after 3 attempts to contact in the past 6 months).

For members receiving housing navigation supports, HP updates CIS+ Status Code to (H8)

HP sends Notice of Adverse Benefit Determination

Result 5: Not eligible for pre-procedure housing

Result 4: Eligible for Housing Navigation Services only, not short-term pre-procedure housing

Result 1: Confirmed eligible for Housing Navigation Supports

HP updates CIS+ Status Code to (H2)

Result 2: Not eligible

HP updates CIS+ Status Code to (H3)

Result 1: Not eligible for short-term recuperative care or short-term post-hospitalization housing.

Result 2: Member has both:
1) short-term recuperative care *or* short-term post-hospitalization housing need and;
2) housing related need

Result 1: Member has all three needs:
1) pre-procedure housing need,
2) housing related need, and;
3) complex behavioral/ physical health need

Result 2: Member has:
1) pre-procedure housing need,
2) housing related need, but
3) *NO* confirmed complex behavioral/ physical health need

HP solicits consent using the CIS+ Member Consent form and conducts person-centered service planning.

Member does not sign form

HP updates CIS+ Status Code to eligible refused (H4)

Member does not sign form

HP solicits consent using the CIS+ Member Consent form and conducts person-centered service planning

Member signs form

HP updates CIS+ Status Code to eligible consented, (HC)

Member signs form, wants Housing Navigation Supports only

Member signs form, wants Medical Respite

Coordinating Services

Does the Member have a CCS plan?

Yes

No

For Members in CCS plans, QI HP conducts warm handoff to the CCS plan

HP authorizes Pre-Tenancy Supports or Tenancy Sustaining Services for up to 3-months at a time and engages a provider

Provider conducts CIS+ Assessment and HP updates CIS+ Status Code to:
1. Pre-Tenancy Supports (H5)
2. Tenancy Sustaining Services (H6)

If there are other needs identified (e.g. LTSS), HP to arrange additional assessment

If Member wants to health coordination, HP to complete Health and Functional Assessment (HFA) and Health Action Plan (HAP)

Provider, in partnership with Member, develops or updates CIS+ Action Plan (initial, quarterly, and discharge)

Provider delivers additional pre-tenancy support (H0044)

Provider delivers additional tenancy sustaining services (H0044)

If the Member is eligible the member can begin receiving pre-tenancy and tenancy sustaining supports, while receiving medical respite

HP authorizes specified days of medical respite

HP engages provider for medical respite services:
1. Pre-procedure housing
2. Recuperative care
3. Post-hospitalization housing

Provider delivers **medical respite** services
1. Short-term pre-procedure housing (S5151 with modifier SC)
2. Recuperative care (S9125 with modifier 22)
3. Short-term post-hospitalization housing (S9125 with modifier SC)

Authorized medical respite period ends

HP engages Member to discuss other CIS+ benefits, or connections to other services (other CIS+ services can be delivered alongside medical respite services)

Member does not need or desire other benefits

Claiming and Payment

Provider submits claim to HP

HP processes and pays CIS+ claim

HP auditing

HP submits encounter data to MQD through Hawaii Prepaid Medical Management Information System (HPMMIS)

Service End: Benefit authorization expires, or member elects to end participation

HP updates CIS+ Status Code based on Member status at end of program:
1. Enrolled, lost to follow up, (H7)
2. Exited to permanent housing, (HP)
3. Exited to temporary housing, (HT)
4. Exited back to homelessness, (HH)
5. Exited other (e.g. death, incarceration, loss of Medicaid coverage), (HM)

If service end is involuntary HP sends Notice of Adverse Benefit Determination

CIS+ Status Code	Description
H1	POTENTIALLY ELIGIBLE
HA	POTENTIALLY ELIGIBLE WITH ENGAGEMENT AUTHORIZED
H2	CONFIRMED ELIGIBLE FOR HOUSING NAVIGATION SUPPORTS
H3	NOT ELIGIBLE FOR HOUSING NAVIGATION SUPPORTS
HC	ELIGIBLE CONSENTED
H4	ELIGIBLE REFUSED
H5	PRE-TENANCY SUPPORTS
H6	TENANCY SUSTAINING SERVICES
H7	ENROLLED LOST TO FOLLOW UP
H8	POTENTIALLY ELIGIBLE UNABLE TO CONTACT
HP	EXITED TO PERMANENT HOUSING
HT	EXITED TO TEMPORARY HOUSING
HH	EXITED BACK TO HOMELESSNESS
HM	EXITED OTHER/ MISCELLANEOUS

Med-QUEST, DHS

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

This referral form should be shared with the Medicaid member's QI Health Plan (see plan contact information at the end of this form). If medical respite is authorized, the QI Health Plan may share information from this authorization form with medical respite facilities to coordinate service provision.

A clinician must review, approve, and sign the medical respite authorization form for health plans to determine member eligibility and authorize CIS+ benefits. Signing clinicians must be a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), or Physician Assistant (PA).

<table>
<tr><th colspan="6">PART 1: CLINICIAN REFERRAL SOURCE AND DIRECTION</th></tr>
<tr><td colspan="3">Signing Clinician Information</td><td colspan="3">Coordinator, if different from the signing clinician</td></tr>
<tr><td colspan="3">Clinician Name:</td><td colspan="3">Coordinator Name:</td></tr>
<tr><td colspan="3">Clinician NPI:</td><td colspan="3">Coordinator Email:</td></tr>
<tr><td colspan="3">Clinician Relationship to Member:</td><td colspan="3" rowspan="3">Coordinator Phone Number:</td></tr>
<tr><td colspan="3">Clinician Phone Number:</td></tr>
<tr><td colspan="3">Clinician Email:</td></tr>
<tr><th colspan="6">PART 2: MEMBER INFORMATION</th></tr>
<tr><td colspan="2">First Name:</td><td colspan="2">Last Name:</td><td colspan="2">MI:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">HMIS#, if known:</td><td colspan="2">Medicaid ID #:</td></tr>
<tr><td>CCS?
☐ No ☐ Yes</td><td colspan="2">Gender
☐ Male ☐ Female ☐ Non-binary
☐ Prefer not to respond</td><td>Veteran?
☐ No ☐ Yes</td><td>Height:</td><td>Weight:</td></tr>
<tr><td colspan="3">Current Location/Address:</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td colspan="3">Mailing Address (if available and different from above):</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td colspan="3">Best Contact Phone Number:</td><td colspan="3">Best Contact Email Address:</td></tr>
<tr><td colspan="6">Any friends or family who can help reach the member?
☐ No ☐ Yes, Name/Phone:</td></tr>
<tr><td colspan="6">Does the member have interpretation needs?
☐ No ☐ Yes, Language:</td></tr>
<tr><th colspan="6">PART 3: SERVICES NEEDED</th></tr>
<tr><td colspan="6">Diagnosis(es):</td></tr>
</table>

What 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, not to exceed six (6) months of medical respite benefits per rolling 12-month period. Post-procedure treatment is limited to three (3) days.
Date of procedure and reason for procedure: _____.

☐ 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/or psychiatric needs. The maximum service length is determined by clinical appropriateness, not to exceed 90 days or six (6) months of medical respite benefits per rolling 12-month period.
Date of hospital admission and reason for admission: _____.

☐ Short-Term Post-Hospitalization Housing: For members in need of housing and limited support to continue recovery from a physical, psychiatric, and/or substance use condition, often 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.
Date of hospital admission and reason for admission: _____.

Recommended medical respite length of stay: _____.

Which clinical eligibility criteria does the member meet (check all that apply):

☐ Has a planned medical procedure requiring preparation care (e.g., colonoscopy) or have a planned medical treatment (e.g., chemotherapy treatment) requiring care prior to or following treatment.
Required for Short-term Pre-Procedure Housing.

☐ In institutional care, which may include an acute care hospital, state mental health hospital, nursing facility, or other inpatient or institutional setting (institutional settings do not include the emergency department).
Required for Short-term Recuperative Care and Short-term Post-Hospitalization Housing.

☐ Has an ongoing physical and/or behavioral health need that would otherwise require continued institutional care if not for receipt of medical respite.
Required for Short-term Recuperative Care and Short-term Post-Hospitalization Housing.

Please attach evidence of checked eligibility criteria, if known (e.g., clinical justification).

Which social eligibility criteria does the member meet?

☐ Homeless ☐ At risk of homelessness ☐ Other, please describe:

Please attach evidence of homelessness, or risk of homelessness, if known.

Does the member also need housing navigation support?

☐ No ☐ Yes

PART 4: MEDICAL CONDITION

Member had a Positive Purified Protein Derivative (PPD) test?	Member had a chest X-ray?
☐ No ☐ Yes Date PPD read:	☐ No ☐ Yes If yes, Chest X-ray Date: If yes, Chest x-ray: ☐ Positive ☐ Negative

Is medical follow-up required for the member?

☐ 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 If no, please describe:

☐ Yes

Does the member have an intact immune system?

☒ No If no, please describe:

☐ Yes

Does member have a history of known communicable diseases?

☐ No ☐ Yes, if yes, list and include date of last episode:

Does the member have other 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 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, please describe with reason and include date of last episode:

Does the member have a history of suicidal behavior?

☐ No ☐ Yes, describe and include date of last episode:

Does the member have a history of substance abuse/chemical dependency? ☐ No ☐ 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 prep 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 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:	

Clinician Signature: _____

Date: _____

CIS+ Medical Respite Authorization Instructions

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

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

Department of Human Services
Med-QUEST Division

Medical Respite Person Centered Service Plan

This plan is your opportunity to learn about the Community Integration Services (CIS+) program, share what is important to you, and explore how the program can best support your goals. You are welcome to involve anyone from your support network in creating this plan. If at any point you want to make changes, your plan can be updated at your request.

A. Contact Information

1. Name (as shown on Medicaid or QI Health Plan Card):	
2. Medicaid or Health Plan ID # (If known):	3. DOB (MM/DD/YYYY):
4. If applicable, name of Guardian or Legal Authorized Representative:	
5. Contact Phone Number (indicate cell or house):	6. Contact Email:

7. What are your medical respite goals and needs? (select all that apply)
   - ☐ Recover in a safe, supportive environment.
   - ☐ Improve how I manage my ongoing health conditions.
   - ☐ Get support to take my medications as prescribed.
   - ☐ Work toward stable, long-term housing.
   - ☐ Keep my follow-up appointments and get connected to regular medical or behavioral health care.
   - ☐ Be part of a community with people who may have similar experiences.
   - ☐ Other: _____

8. *[Optional]* What are some barriers to reaching your medical respite goals? (select all that apply)
   - ☐ My health conditions are complicated, and it's hard for me to keep track of everything.
   - ☐ I sometimes have trouble understanding medical information or instructions.
   - ☐ I want support, but I don't always feel ready to make big changes.
   - ☐ Other: _____
   - ☐ None

9. What medical respite benefit are you receiving or are going to receive?
   - ☐ Short-term pre-procedure housing
   - ☐ Short-term post-hospitalization housing
   - ☐ Short-term recuperative care

10. Are you interested in receiving Housing Navigation Supports while in medical respite? This service offers support to help you work toward permanent housing.

☐ Yes, I am interested in Housing Navigation Supports
☐ Maybe, I would like to learn more at another time
☐ No

Sign below if you agree to this person-centered service plan.

Member Signature: _____ Date: _____

If not signing for self, guardian, or legal authorized representative name:

_____

For Health Plan or Delegate Use Only
Was the plan authorized verbally? ☐ Yes ☐ No Health Plan or Delegate Organization Name:_____ Staff Name (print): _____ Staff Signature: _____ Date: _____