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="5">PART 1: CLINICIAN REFERRAL SOURCE AND DIRECTION</th></tr>
<tr><td colspan="3">Signing Clinician Information</td><td colspan="2">Coordinator, if different from the signing clinician</td></tr>
<tr><td colspan="3">Clinician Name:</td><td colspan="2">Coordinator Name:</td></tr>
<tr><td colspan="3">Clinician NPI:</td><td colspan="2">Coordinator Email:</td></tr>
<tr><td colspan="3">Clinician Relationship to Member:</td><td colspan="2" 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="5">PART 2: MEMBER INFORMATION</th></tr>
<tr><td colspan="2">First Name:</td><td>Last Name:</td><td colspan="2">MI:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td>HMIS#, if known:</td><td colspan="2">Medicaid ID #:</td></tr>
<tr><td>CCS?
☐ No ☐ Yes</td><td>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="2">Current Location/Address:</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td colspan="2">Mailing Address (if available and different from above):</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td colspan="2">Best Contact Phone Number:</td><td colspan="3">Best Contact Email Address:</td></tr>
<tr><td colspan="5">Any friends or family who can help reach the member?
☐ No ☐ Yes, Name/Phone:</td></tr>
<tr><td colspan="5">Does the member have interpretation needs?
☐ No ☐ Yes, Language:</td></tr>
<tr><th colspan="5">PART 3: SERVICES NEEDED</th></tr>
<tr><td colspan="5">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