Department of Human Services
Med-QUEST Division

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

This form should be shared with the Medicaid member's QI Health Plan (see QI Health 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 qualified health professional must review, approve, and sign the Medical Respite Authorization Form for Health Plans to determine member eligibility and authorize CIS+ benefits. Signing qualified health professionals 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 colspan="2">Last Name:</td><td>Middle Initial:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">HMIS #, if known:</td><td>Medicaid ID #:</td></tr>
<tr><td>Community Care Services (CCS)?
☐ Yes
☐ No</td><td>Sex
☐ Male ☐ Female
☐ Prefer not to respond</td><td>Veteran?
☐ Yes
☐ No</td><td>Height:</td><td>Weight:</td></tr>
<tr><td colspan="3">Current Location/Address:</td><td colspan="2">City, State, Zip Code:</td></tr>
<tr><td colspan="3">Mailing Address (if available and different from above):</td><td colspan="2">City, State, Zip Code:</td></tr>
<tr><td colspan="3">Phone Number:</td><td colspan="2">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">Which Medical Respite service do you recommend for the member?

☐ <u>Short-Term Pre-Procedure Housing</u>: 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 are limited to three (3) days.
1. Procedure:
2. Date of Procedure:
3. Reason for Procedure (include ICD-10 code(s)):</td></tr>
</table>

☐ 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. Short-Term Recuperative Care allows referrals from institutions and other referral sources (e.g., community provider, street medicine team, emergency department, etc.)*

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 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 not admitted to an institutional setting):

3d. If Medical Respite was 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)

☐ 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, 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 institution?

3. Date of initial institution admission:
4. Reason for initial institution admission:
5. Tentative institution discharge date (if available):
6. Institution type:
   ☐ Acute care hospital
   ☐ Nursing facility
   ☐ Inpatient psychiatric facility
   ☐ Other institutional setting: _____

Recommended Medical Respite length of stay:

Recommended Medical Respite stay extension (if applicable)
Original Medical Respite discharge date:
Recommended Medical Respite discharge date:

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 services?
☐ Yes ☐ No

PART 4: MEDICAL CONDITION

Member had a Positive Purified Protein Derivative (PPD) test? ☐ No ☐ Yes Date PPD read:	Member had a chest X-ray? ☐ 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 ☐ Yes
If no, please describe:

Does the member have an intact immune system?
☐ No ☐ Yes
If no, please describe:

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
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 abuse/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 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 Form Instructions

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

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