NURSING FACILITY TRANSITION/ DIVERSION TO ASSISTED LIVING REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
Here for you

Nursing Facility Transition/Diversion to Assisted Living is a Community Supports service offered to eligible Medi-Cal members. This service is to assist eligible members to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. This service does not include room and board.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF), this service will include wrap-around services as follows: assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. This service also includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

If this is a self-referral, please call SFHP's Care Management Intake line during business hours of 8:30am – 5:00pm, Monday – Friday: **1(415) 615-4501**, and an SFHP staff member can assist you.

If the referral is being completed by a provider or other agency, please complete this form, and securely email to San Francisco Health Plan's Care Management department at caremanagement_referrals@sfhp.org.

MEMBER/PATIENT INFORMATION

Member must already be enrolled with SFHP for their Medi-Cal coverage

First Name:	Last Name:
Date of Birth (MM/DD/YYYY):	Preferred Language:
SFHP ID#:	Referral Date:
Primary Phone Number:	Alternate Phone Number:

REFERRING ENTITY INFORMATION

- ☐ PCP/Specialist
- ☐ Community Based Organization
- ☐ Community Supports Provider
- ☐ ECM provider
- ☐ Friend/Family
- ☐ Hospital
- ☐ Self
- ☐ Other (please specify):

Name:	Phone Number:
	Email:

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Has the patient/member been informed that a Community Supports referral is being requested? (please select one)

☐ Yes

If Yes, has the member given approval to continue with this service?

☐ Yes

☐ No

☐ No

Is the member enrolled in Enhanced Care Management (ECM)?

☐ Yes

☐ No

ELIGIBILITY CRITERIA

If No is checked for any of the following, **STOP**. Member does not meet eligibility requirement.

1. **Has the member resided in a skilled nursing facility for 60 or more days or resided in a hospital for 60 or more days receiving skilled nursing facility level care?**
   ☐ Yes
   ☐ No
2. **Is the member willing to live in a Residential Care Facility for Elderly or assisted living facility instead of a skilled nursing facility which would require member to pay a portion of income for room and board?**
   ☐ Yes
   ☐ No
3. **Does the member require assistance completing Activities of Daily Living (ADLs) such as meals, medication administration, transportation, etc.?**
   ☐ Yes
   ☐ No

Additional comments:

ATTESTATION STATEMENT

☐ **I, the referent, attest that to the best of my knowledge; the member meets the eligibility criteria and does not fall within the exclusion criteria.**

Signature: | Today's Date (MM/DD/YYYY):