RESPITE SERVICES (FOR CAREGIVERS) REFERRAL FORM

Respite Services are provided to caregivers of members who require intermittent temporary supervision. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only. For more information, review the Respite Services Authorization Guide.

Complete and submit this referral form with the *Medi-Cal – Prior Authorization Request Form – Outpatient* either online (recommended) at **provider.healthnetcalifornia.com** or by **fax at 800-743-1655**.

☐ **Initial request** ☐ **Extension request** ☐ **Member consented to respite services referral.**

Type of Respite Request

☐ **Home respite services** (provided in the member's own home or another location being used as the home)

☐ **Facility respite services** (provided in an approved out-of-home location)

Eligibility Criteria

Member must meet both:

☐ Member lives in the community and is compromised in their activities of daily living (ADLs) requiring dependency on a qualified caregiver.

☐ Member's qualified caregiver, who provides most of the member's support, requires caregiver relief to avoid institutional placement for the member.

OR meets the following:

☐ Member is a child who previously received respite services under the pediatrics palliative care waiver.

Monthly respite hours:_____

Member Information

Member name:		**Date of birth (DOB)**:
Medi-Cal ID:	**Phone number:**	**Preferred language:**
Home address:		
Contact name: **(if different than member)**		**Relationship:**
Phone number:		**Preferred language:**
Member height:		**Member weight:**

Member IHSS application status: ☐ In review ☐ Approved – IHSS hours per month:_____
☐ Denied ☐ N/A

Member's diagnosis:

Member's need for caregiver services:

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Member Information, continued	
Name of caregiver who needs respite:	
Indicate how many hours and specify which day(s) respite is needed. **Hours _____Day(s)** ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	
Preferred Time: ☐ Morning ☐ Afternoon ☐ Overnight ☐ No preference	
Other needs/requests (i.e., hoyer lift, male caregiver):	
Special instructions to enter residence:	
Community Supports Provider Information (Servicing Organization)	
Organization name:	
Tax identification (ID):	**National Provider Identifier (NPI):**
Staff name:	**Title:**
Phone number:	**Fax number**: