CenCal Health's Recuperative Care Prior Authorization Checklist

CenCal HEALTH
Local. Quality. Healthcare.

Recuperative Care, also known as Medical Respite, Community Supports assists members experiencing homelessness who no longer require hospitalization, but still need to heal from an injury or illness, and whose conditions would be exacerbated by an unstable living environment.

Is member interested in a voluntary recuperative care stay? ☐ **Yes** ☐ **No**

IF NO, Please stop and do not continue

Please complete form and attach required documents.

Referral Source Information

Individual Name:

Hospital:

Phone Number: Fax Number:

Member Information

Member Name:

Member's Medi-Cal Client ID # (CIN): Member's Date of Birth:

Member Address (if known):

Member Primary Phone Number: Best Time to Contact:

Member's Preferred Language:

Gender: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other

Member's PCP: PCP Phone Number:

Pharmacy Information:

Homeless Status HUD

☐ Chronically Homeless ☐ Homeless

Current Living Location upon admission to hospital

☐ Street ☐ Shelter ☐ Homeless ☐ Interim Housing ☐ LTC ☐ Recuperative Care ☐ Other:

Hospital Admission Information

Date of admission:

Reason for Admission:

Member's current hospital/SNF location, if applicable:

Diagnoses:

Weight: Height: Allergies:

Communicable disease: ☐ Yes ☐ No **If YES, please include documentation**

Colonized: ☐ Yes ☐ No **If YES, please include documentation**

Please answer ALL questions *(If applicable)*

1) Can Member Self Represent? ☐ Yes ☐ No

2) Is Member Independent w/ADLs? ☐ Yes ☐ No

If NO, please explain:

3) Self-administer all medication? ☐ Yes ☐ No

If NO, please explain:

4) Continent with bladder? ☐ Yes ☐ No

If NO, please explain:

5) Continent with bowel? ☐ Yes ☐ No

If NO, can self-care be completed independently? ☐ Yes ☐ No

6) Colostomy Care? ☐ Yes ☐ No

If YES, who is providing colostomy supply?

7) Catheter Care? ☐ Yes ☐ No

If YES, can it be done independently? ☐ Yes ☐ No

8) Can member perform wound care independently? ☐ Yes ☐ No

If NO, please arrange with Home Health.

Questions continued >

(cont.): Please answer ALL questions *(If applicable)*

9) Wheel Chair? ☐ Yes ☐ No

Please check one of the following: ☐ Manual Wheel Chair ☐ Electrical Wheel Chair

10) Oxygen? ☐ Yes ☐ No

Please indicate how many liters' member will be discharged with:

11) Wound Vac? ☐ Yes ☐ No

12) Bipap? ☐ Yes ☐ No

13) CiPap? ☐ Yes ☐ No

14) Other:

Behavioral Health/Mental Health

Alcohol? ☐ Yes ☐ No

Cocaine? ☐ Yes ☐ No

Heroin? ☐ Yes ☐ No

Methamphetamines? ☐ Yes ☐ No

Medication Assistance for Substance Abuse needed? ☐ Yes ☐ No

Fentanyl use? ☐ Yes ☐ No

Other:

Mental Health History:

Any current relationship with Mental Health or recovery treatment? ☐ Yes ☐ No

If yes, please specify:

Notes:

Questions continued >

Additional Clinical Information

IV Antibiotics? ☐ Yes ☐ No

If YES, please attach documentation

Medical/Medication Management & Education: ☐ Yes ☐ No

Wound Care: ☐ Yes ☐ No

Physical Therapy: ☐ Yes ☐ No

DME Information

Walker: ☐ Yes ☐ No

Cane: ☐ Yes ☐ No

Crutches: ☐ Yes ☐ No

Other:

Home Health: Must be arranged prior to discharge to recuperative care site

Check here if the member does not have Home Health orders at this time. ☐

Name of Home Health Provider:

Phone Number: Confirmation start of services:

Follow up appointments

Prior to hospital discharge, please arrange all follow up appointments required.

Please list the following:

Provider Name	Phone Number	Appointment Date/Time	Appointment Reason	Address

Questions continued >

Please attach Documents: All documents required upon submission as applicable*

☐ Face Sheet

☐ CXR or PPD (within last year)

☐ History & Physical

☐ S.W. Notes *(if applicable)*

☐ Consultation Notes *(if applicable)*

☐ Recent PT/OT/ Speech Therapy *(if applicable)*

☐ Medication List

☐ Wound Care Notes *(if applicable)*

☐ COVID-19 Test Required

☐ Psych Notes *(if applicable)* – Please include the last two days of nursing documentation

☐ Home Health Order *(if applicable)*

ONLY for Recuperative Care Transfers:
Please include hospital clinical documentation and recup site progress notes

After completion, submit the form with the referral to the Recuperative Care Provider or secure fax (805) 681-3039.
Incomplete forms and/or missing documents will delay decisions.

Additional Info: