

# Cal-AIM: Community Support Services Referral Form

Please complete this form to share member's information that will assist in identifying appropriate criteria for Community Support Services being requested. Please select service(s):

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|--|--|
| <input type="checkbox"/> Housing Transition Navigation Service   | <input type="checkbox"/> Recuperative Care (Medical Respite)                   |
| <input type="checkbox"/> Housing Deposits                        | <input type="checkbox"/> Respite Services                                      |
| <input type="checkbox"/> Housing Tenancy and Sustaining Services | <input type="checkbox"/> Personal Care and Homemaker Services                  |
| <input type="checkbox"/> Short-Term Post-Hospitalization Housing | <input type="checkbox"/> Medically Tailored Meals or Medically Supportive Food |
| <input type="checkbox"/> Day Habilitation                        |  |

## Provider's Information

<b>Date:</b>	<b>Email:</b>		
<b>Organization's Name:</b>	<b>Name of person filling out form:</b>	<b>Phone #:</b>	<b>Fax #:</b>

## Member's Information

<b>CIN #:</b>	<b>First Name:</b>	<b>Last Name:</b>
<b>Address:</b>	<b>County:</b>	<b>Phone Number:</b>

## Member's Diagnosis

	Description and/or ICD-10 Diagnosis Code	ED visits
<b>Mental Health:</b> SMI/Behavioral Health		
<b>Physical Health:</b>		
<b>SUD services:</b> Drug/Alcohol		
<b>Hospitalizations:</b>		

## Additional Information:

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Submit form with TAR request or send to [CommunitySupports@partnershiphp.org](mailto:CommunitySupports@partnershiphp.org) inbox, so the referral can be made to appropriate provider.

For all other questions, please contact [CalAIM@partnershiphp.org](mailto:CalAIM@partnershiphp.org).