



**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):

- Housing Transition Navigation Service
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Personal Care and Homemaker Services
- Medically Tailored Meals or Medically Supportive Food

**Date:**

**Provider's Information**

Organization's Name:	Name of person filling out form:	Phone #:	Fax #:

**Member's Information**

CIN #:	First Name:	Last Name:
Address:	County:	Phone Number:

**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:**

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

For all other questions please send them to [CalAIM@partnershiphp.org](mailto:CalAIM@partnershiphp.org)