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
- ☐ Day Habilitation
- ☐ Recuperative Care (Medical Respite)
- ☐ Respite Services
- ☐ Personal Care and Homemaker Services
- ☐ Medically Tailored Meals or Medically Supportive Food

Provider's Information

Date:	Email:		
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
Mental Health: SMI/Behavioral Health		
Physical Health:		
SUD services: Drug/Alcohol		
Hospitalizations:		

Additional Information:

Submit form with TAR request or send to CommunitySupports@partnershiphp.org inbox, so the referral can be made to appropriate provider.

For all other questions, please contact CalAIM@partnershiphp.org.