

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 | <input type="checkbox"/> Asthma Remediation |

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:

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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.