

Community Supports (CS) Referral Form

Caregiver Respite		
HCPCS Code	HCPCS Description	Modifier
H0045	Respite care services, not in the home; per diem	U6
S5151	Unskilled respite care, not hospice; per diem	U6
S9125	Respite care, in the home; per diem	U6

Caregiver Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. **Caregiver Respite is not meant as a substitute for ongoing care and is only allowable to avoid placements. Please note that Members cannot exceed 336 hours of Caregiver Respite services per calendar year. Referrals must come from a member of the established healthcare team (e.g., primary care providers, specialists, inpatient providers, or other members of the clinical care team) or MCP and must include clinical documentation addressing member's caregiver needs for caregiver respite services.**

☐ Member lives in the community and is compromised in their Activities of Daily Living (ADLs) requiring dependency on a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. Eligible managed care Members may include, but are not limited to, children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, children/youth in foster care, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program, and Members with Complex Care Needs.

Member Information	
Member Name:	DOB:
Medi-Cal ID/CIN:	Preferred Language:
Residential Address:	
City:	Zip Code:
Primary Phone Number:	Secondary Phone Number:
Alternate Contact Name:	Alt. Contact Phone:

Requested Service	
Request type: ☐ Initial ☐ Reauthorization	Setting: ☐ Member's home ☐ Approved out-of-home setting
Frequency/schedule Requested: _____	
Hours per session: _____	Total requested hours: _____

Community-Living Requirement	
The member currently lives: ☐ In a private Home/Condo/Apartment/Mobile Home ☐ In another setting; describe: _____	Describe the member's current living arrangement, including who resides with the member: _____

Member Functional Need and Supervision Assessment

Mark one level for each activity and add brief frequency or safety details in the notes below or if physical therapy or occupational therapy assessment is available attach to the referral form.

Activity	Independent	Supervision / cueing	Partial assistance	Extensive / total Assist	Notes
Bathing	☐	☐	☐	☐	Frequency: Safety:
Dressing	☐	☐	☐	☐	Frequency: Safety:
Toileting / continence	☐	☐	☐	☐	Frequency: Safety:
Eating / feeding	☐	☐	☐	☐	Frequency: Safety:
Transfers / mobility	☐	☐	☐	☐	Frequency: Safety:

Activity	Independent	Supervision / cueing	Partial assistance	Extensive / total Assist	Notes
Medication-related supervision	☐	☐	☐	☐	Frequency: Safety:
Cognitive / behavioral supervision	☐	☐	☐	☐	Frequency: Safety:
Other basic self-help need	☐	☐	☐	☐	Frequency: Safety:
Describe specific functional limitations and what occurs without caregiver assistance/supervision: _____					
Relevant diagnoses/conditions: _____					

Primary Caregiver Assessment

Primary caregiver present during the visit? ☐ Yes ☐ No If No, explain _____	How long has the caregiver been providing service to the member: ☐ Less than 1 year ☐ One to five years ☐ More than five years ☐ More than ten years
Caregiver name: _____ Phone: _____	Relationship: ☐ Unpaid family/friend ☐ Paid family/friend ☐ IHSS provider ☐ Private paid caregiver ☐ Other: _____
Caregiver listed above provides care: days/week; _____ hours/day _____	Provides most daily support? ☐ Yes ☐ No
Caregiver routinely provides (check all): ☐ ADLs ☐ IADLs ☐ Safety supervision ☐ Cognitive/behavioral supervision ☐ Mobility/transfers ☐ Meals ☐ Medication support ☐ Appointment support ☐ Transportation ☐ Other: _____	
Why is the member dependent on this caregiver, and why is another adequate caregiver unavailable during the requested periods? _____	

Caregiver Relief and Placement Risk

Reason for temporary relief (check all): ☐ Fatigue/burnout ☐ Caregiver health/treatment ☐ Essential appointments/activities ☐ Temporary absence ☐ Vacation ☐ Other: _____	If respite is not provided, increased risk of: ☐ Hospitalization ☐ SNF/institutional placement Doctors Justification for institutional placement: _____
Describe the current need for relief, precipitating circumstances, and consequences without respite: _____	Describe the specific pathway to institutional placement and how respite will reduce that risk: _____
Caregiver strain/burnout assessment completed? ☐ Yes ☐ No If Yes: ☐ Attached ☐ Findings summarized: _____	Assessment date/tool (if known): _____ Caregiver Self-Assessment Questionnaire is attached with this form.

Existing Services and Non-Duplication Review

Current supports (check all that apply): ☐ IHSS ☐ MSSP ☐ CBAS ☐ PACE ☐ Regional Center respite ☐ VA caregiver services ☐ Hospice ☐ Other county/community respite program: _____ ☐ None	Do any listed services provide respite or cover the same requested need/time? ☐ Yes ☐ No If Yes, explain below.
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Referring Provider

Referrer attestation: I certify that the information is accurate to the best of my knowledge; the request is for short-term, non-medical caregiver relief; and available information has been reviewed for functional need, caregiver dependency, placement risk, and non-duplication.	
Referring organization: _____	NPI: _____
Referring Doctor/Extender: _____	Title: _____
Phone: _____ Email: _____	Signature: _____ Date: _____
Referring provider role: ☐ PCP ☐ NP ☐ Specialist ☐ PA ☐ Hospital/inpatient physician	

Caregiver Self-Assessment Questionnaire

How are YOU?

Caregivers are often so concerned with caring for the relative's needs that they lose sight of their own well-being. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have ...

- | | | | |
|--|--|---|--|
| 1. Had trouble keeping my mind on what I was doing.... | ☐ Yes ☐ No | 13. Had back pain..... | ☐ Yes ☐ No |
| 2. Felt that I couldn't leave my relative alone..... | ☐ Yes ☐ No | 14. Felt ill (headaches, stomach problems or common cold)..... | ☐ Yes ☐ No |
| 3. Had difficulty making decisions..... | ☐ Yes ☐ No | 15. Been satisfied with the support my family has given me..... | ☐ Yes ☐ No |
| 4. Felt completely overwhelmed..... | ☐ Yes ☐ No | 16. Found my relative's living situation to be inconvenient or a barrier to care..... | ☐ Yes ☐ No |
| 5. Felt useful and needed | ☐ Yes ☐ No | 17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. | _____ |
| 6. Felt lonely..... | ☐ Yes ☐ No | 18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. | _____ |
| 7. Been upset that my relative has changed so much from his/her former self..... | ☐ Yes ☐ No | Comments:
(Please feel free to comment or provide feedback.)

_____ | |
| 8. Felt a loss of privacy and/or personal time..... | ☐ Yes ☐ No | | |
| 9. Been edgy or irritable..... | ☐ Yes ☐ No | | |
| 10. Had sleep disturbed because of caring for my relative..... | ☐ Yes ☐ No | | |
| 11. Had a crying spell(s)..... | ☐ Yes ☐ No | | |
| 12. Felt strained between work and family responsibilities... | ☐ Yes ☐ No | | |

Self-Evaluation

To determine the score:

1. Reverse score questions 5 and 15.
For example, a "No" response should be counted as a "Yes" and a "Yes" response should be counted as a "No."
2. Total the number of "yes" responses.

To interpret the score

Chances are that you are experiencing a high degree of distress if any of the below is true:

- If you answered "Yes" to either or both questions 4 and 11
- If your total "Yes" scores = 10 or more
- If your score on question 17 is 6 or higher
- If your score on question 18 is 6 or higher

Next Steps

- Consider seeing a doctor for a check-up for yourself
- Consider having some relief from caregiving
(Discuss with your healthcare provider or a social worker the resources available in your community.)
- Consider joining a support group

Valuable resources for caregivers

HealthinAging.org

(800) 563-4916 | www.healthinaging.org

Caregiver Action Network

(202) 454-3970 | www.caregiveraction.org

Eldercare Locator

(a national directory of community services)

(800) 677-1116 | www.eldercare.gov

Family Caregiver Alliance

(800) 445-8106 | www.caregiver.org

Medicare Hotline

(800) 633-4227 | www.medicare.gov

National Alliance for Caregiving

(301) 718-8444 | www.caregiving.org

Local resources and contacts:

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This questionnaire was originally developed and tested by the American Medical Association.

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