

RESPITE SERVICES (FOR CAREGIVERS) REFERRAL FORM

Respite Services are provided to caregivers of members who require intermittent temporary supervision. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only. For more information, review the [Respite Services Authorization Guide](#).

Complete and submit this referral form with the *Medi-Cal – Prior Authorization Request Form – Outpatient* either online (recommended) at provider.healthnetcalifornia.com or by fax at **800-743-1655**.

☐ Initial request ☐ Extension request ☐ Member consented to respite services referral.		
Type of Respite Request		
☐ Home respite services (provided in the member's own home or another location being used as the home)		
☐ Facility respite services (provided in an approved out-of-home location)		
Eligibility Criteria		
Member must meet both:		
☐ Member lives in the community and is compromised in their activities of daily living (ADLs) requiring dependency on a qualified caregiver.		
☐ Member's qualified caregiver, who provides most of the member's support, requires caregiver relief to avoid institutional placement for the member.		
OR meets the following:		
☐ Member is a child who previously received respite services under the pediatrics palliative care waiver.		
Monthly respite hours: _____		
Member Information		
Member name:		Date of birth (DOB):
Medi-Cal ID:	Phone number:	Preferred language:
Home address:		
Contact name: (if different than member)		Relationship:
Phone number:		Preferred language:
Member height:		Member weight:
Member IHSS application status: ☐ In review ☐ Approved – IHSS hours per month: _____ ☐ Denied ☐ N/A		
Member's diagnosis:		
Member's need for caregiver services:		

Member Information, continued

Name of caregiver who needs respite:

Indicate how many hours and specify which day(s) respite is needed.

Hours _____ Day(s) ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Preferred Time: ☐ Morning ☐ Afternoon ☐ Overnight ☐ No preference

Other needs/requests (i.e., hooyer lift, male caregiver):

Special instructions to enter residence:

Community Supports Provider Information (Servicing Organization)

Organization name:

Tax identification (ID):

National Provider Identifier (NPI):

Staff name:

Title:

Phone number:

Fax number: