Recuperative Care & Short-Term Post-Hospitalization Housing (STPHH)

CenCal HEALTH
Local. Quality. Healthcare.

August 2025

Step 1: Please contact one of our below provider for availability prior to completing this form

Service	Provider Name	Contact
STPHH	Path	SBCalAIM@epath.org
STPHH	D & J Transitions Inc	805-332-3439
Recup	Cottage Recuperative Care	805-569-7302
Recup	Good Samaritan Shelter	805-621- 6878
Recup	Community Action Partnership of SLO County (CAPSLO)	805-458-2895

Step 2: Please fill out all applicable information below and proceed to Steps 3 and 4.

Referrer Information (Email required for notifications on referral status)

Referral Date: Referred by:

Agency or Relationship to Member:

Referring Provider NPI (if applicable):

Phone: Fax: Email:

Member Consent

Does the member agree to be referred to the selected Community Supports program(s)?:

◯ Yes ◯ No *(If "No," do not continue with this referral.)*

If the member cannot give consent, a representative may sign for them.

Authorized Representative Name:

Relationship to Member:

Step 3: Indicate the Community Supports program(s) the member is interested in by marking the appropriate checkboxes. Ensure all required fields are completed prior to submission.

☐ **Recuperative Care (RC)**

Short-term housing for members recovering from a medical or behavioral health condition who lack a safe place to heal. Helps avoid hospital readmission and connects to follow-up care.

Required: Attach Recuperative Care/Short-term medical referral form and relevant documentation.

Coordination (check all that apply):

- ◯ Receiving HTNS
- ◯ Needs HTNS referral
- ◯ HTNS provider = RC provider
- ◯ Receiving ECM
- ◯ Needs ECM referral
- ◯ ECM provider = RC provider

Eligibility – must meet **ALL** of the following criteria:

- ◯ Recovering from a medical or behavioral health condition
- ◯ Experiencing or at risk of homelessness

☐ **Short-Term Post-Hospitalization Housing (STPH)**

Temporary housing support for members on continuing recovery after discharge from a facility (e.g., hospital, jail, residential treatment).

Required: Attach Recuperative Care/Short-Term Post-Hospitalization referral form and relevant documentation.

Coordination (check all that apply):

- ◯ Receiving HTNS
- ◯ Needs HTNS referral
- ◯ HTNS provider = STPH provider
- ◯ Receiving ECM
- ◯ Needs ECM referral
- ◯ ECM provider = STPH provider

Eligibility – must meet **ALL** of the following criteria:

- ◯ Exiting an institution (e.g., hospital, SNF, psychiatric/SUD facility, jail, or recuperative care)
- ◯ Experiencing or at risk of homelessness
- ◯ Ongoing physical or behavioral health needs that would require institutional care without this support (as determined by a qualified health professional)

AND

ONE of the following criteria:

- ◯ Enrolled in ECM
- ◯ Has serious chronic condition(s)
- ◯ Has serious mental illness
- ◯ At risk of institutionalization or needs SUD residential care

Step 4: Fill out all applicable information and Submit the completed referral form and all supporting documentation directly to the contracted Community Supports provider

Incomplete forms or missing documents will delay processing. Attach relevant medical records, H&P, medication lists, wound care/psych notes, and discharge summary if available.

MEMBER INFORMATION

Member Name: Member CIN:

Date of Birth: Currently Hospitalized or in Facility: ◯ YES ◯ NO

If Yes, exiting from: ◯ Hospital ◯ SNF ◯ Jail ◯ SUD/MH Residential Facility ◯ Recuperative Care

◯ Other:

Anticipated Date of Discharge/Exit:

Current Living Situation:

◯ Shelter
◯ Unsheltered
◯ Interim Housing
◯ LTC
◯ Recuperative Care
◯ Other:

CLINICAL ATTESTATION

Required for all STPHH referrals

◯ I attest that the member listed above has an ongoing physical or behavioral health need and would require continued institutional-level care if Short-Term Post-Hospitalization Housing is not provided.

Name of Qualified Health Professional:

License/Credentials: Date:

Signature

HEALTH DIAGNOSIS

Required for all Recuperative Care and STPHH referrals

Qualifying Diagnosis:

Describe why Recuperative Care or STPHH is needed to support discharge (e.g., wound care, isolation risk, unstable housing):

HOME HEALTH PROVIDER

Services Ordered: ◯ PT ◯ OT ◯ ST ◯ Wound Care

Provider Name:

Phone Number:

HEALTH INFORMATION

COVID Vaccine: ◯ Yes ◯ No Booster: ◯ Yes ◯ No

TB Test or Chest X-Ray: ◯ Yes ◯ No Date: ◯ Positive ◯ Negative

Neuro:

◯ A&O to Person
◯ Place
◯ Time
◯ Situation

Respiratory: ◯ Requires O2 (Explain):

GI/GU:

◯ Incontinent of Bowel
◯ Incontinent of Bladder
◯ Colostomy/Ileostomy
◯ Foley Catheter

Tube Feeding: ◯ Yes ◯ No

Ambulation / Mobility:

Independent with ADLs: ◯ Yes ◯ No

Able to ambulate at least 100 feet with or without DME: ◯ Yes ◯ No

Uses DME: ◯ Yes ◯ No If Yes, explain:

Fractures in past 30 days: ◯ Yes ◯ No

Recent Surgery (past 30 days): ◯ Yes ◯ No

Surgery Type: ◯ Inpatient ◯ Outpatient Date:

Integumentary:

Wounds Present: ◯ Yes ◯ No

If Yes, describe location, size, stage:

Independent with Wound Care: ◯ Yes ◯ No

HEALTH INFORMATION (cont.)

Reproductive Health:

◯ Pregnant ◯ Post partum Delivery date/Estimated due date:

Infections:

Communicable Disease/Isolation Precautions: ◯ Yes ◯ No

If Yes, describe:

IV Antibiotics: ◯ Yes ◯ No Frequency:

Psycho-Social & Behavioral Information

Registered Sex Offender: ◯ Yes ◯ No

Member Has: ◯ Car ◯ Spouse/Partner ◯ Service Animal ◯ Pets ◯ Children

Substance Use: ◯ None ◯ Alcohol ◯ Cocaine ◯ Heroin ◯ Methamphetamine ◯ Opioids

◯ Other: Last Use Date:

Mental Health Diagnosis:

◯ Anxiety ◯ Bipolar ◯ Cognitive Impairment ◯ Depression ◯ Schizophrenia ◯ Trauma-Related

◯ Severe and persistent mental illness ◯ Other:

Current Treatment:

◯ Requires ADL Assistance If Yes, explain:

Chronic Disease Management:

◯ Diabetes: ◯ Insulin ◯ Oral Meds ◯ Anticoagulants ◯ Requires INR/PT/PTT Checks

◯ Requires Assistance with Medications ◯ Blood Pressure Management

List Medications or Attach Current Medication List: