

Personal Care and Homemaker Services Patient Guide

For **Molina Healthcare** members and their caregivers

What is Personal Care and Homemaker Services for

This service gives short-term help with daily activities. Help may include bathing, dressing, walking, using the toilet, eating, cooking, cleaning, shopping, or laundry. The goal is to help you stay safe at home.

Who may qualify

- You need help with daily activities and do not have enough support; or
- Without help, you may need hospital care or care in a nursing facility.

Molina also reviews your IHSS situation. This service may help while you apply for IHSS, wait for an IHSS re-evaluation for more hours, or need short-term help after IHSS finds you ineligible. Molina reviews the request and decides if you qualify.

How to request or renew this service

Important

Your treating healthcare provider must complete the Molina Community Supports referral form and fax the request and supporting records to Molina. Molina must review and approve the request before new services begin or renewed services continue.

Which situation applies to you

If you are requesting services for the first time	If you already receive services and need a renewal
Take this package to your treating provider. Molina must approve the request before personal care and homemaker services can begin.	Contact your provider as soon as possible. If Molina does not approve the renewal before your current authorization ends, services may be paused or interrupted.

What can you do

- 1. Contact your treating healthcare provider.** Tell the office that you are requesting personal care and homemaker services through Molina's Community Supports benefit.
- 2. Take this full package to the office.** It includes a page for your provider, a fax cover, and the Molina referral form.
- 3. Explain the help you need.** Explain what daily activities you cannot safely do alone, what help you need, and what may happen if caregiver help is not available.
- 4. Ask the office to fax the request.** The complete referral form and supporting records must be faxed to Molina at (833) 305-3130.
- 5. Follow up.** Ask the office for the date the fax was sent. Tell Coast Care so we can track your referral. Call the Member Services number on your Molina ID card if you need to ask whether Molina received the request.

What to tell your provider

You can use your own words. This is just an example:

I would like to request Personal Care and Homemaker Services through Molina's Community Supports benefit. I need help with daily activities so I can remain safe at home. Coast Care gave me this package with the Molina form and fax instructions. Please review whether this service is right for me and, if appropriate, complete and fax the request to Molina.

Additional questions and support

What to bring to your appointment

- Your Molina member ID card.
- Your current medicine list, if you have one.
- Any papers you have from IHSS. For example, bring documents showing that you applied, were denied, asked for more hours, or currently receive IHSS services.

Important information about Personal Care

If you do not have IHSS papers or do not know what IHSS is, tell your provider. Your provider will review your information and complete the Molina form.

IHSS application and re-evaluation information

For information about applying for IHSS, or if you already receive IHSS and need to ask about a re-evaluation, visit the [San Diego County IHSS website](#) or call 800-339-4661.

What to do after the request is faxed

- Ask the provider's office to confirm the date the request was faxed to Molina.
- Ask the office to keep the fax confirmation page.
- Tell Coast Care when the request was sent so we can also track it.
- Call the Member Services number on your Molina ID card to ask if Molina received the request and when you may expect a decision.

Remember: Molina decides whether to approve the request and how long the review takes. Coast Care cannot guarantee approval or continued services after an authorization ends.

If there is a delay or possible interruption

- Tell Molina whether you already receive services and when your authorization ends or ended.
- Explain how the delay affects your health, safety, daily activities, supervision, or access to care.
- Tell Molina when your provider faxed the request, if you know the date.

SHARE THIS PAGE WITH YOUR TREATING HEALTHCARE PROVIDER

Molina Personal Care and Homemaker Services Authorization Checklist

Please complete the included Molina Community Supports referral form, attach the records needed to support your clinical decision, and fax the full request to Molina at (833) 305-3130.

Complete the Molina referral form

- Complete all required member, clinical, service, consent, and attestation fields.
- Enter the member's diagnoses and ICD-10 codes that support the request.
- Document the member's ADL and functional limitations and the level of help required.
- Confirm that the member needs ADL or IADL help and has no adequate support, or is at risk of hospitalization or nursing-facility placement.
- Select the IHSS pathway that applies and enter the requested dates and hours.
- Describe the member's physical limitations and the exact help needed, such as bathing, dressing, meals, shopping, housekeeping, or transfers.

Attach supporting records

- IHSS referral documentation, if the member was referred and is searching for a caregiver.
- IHSS reassessment request, if the member receives IHSS and needs more hours while the request is pending.
- IHSS Notice of Action denial, if the member is not eligible for IHSS and the notice is available.
- Clinical records supporting the member's functional limitations and need for services.

Identify Coast Care as the requested provider

Requested Community Supports Provider: Coast Care

NPI: 1689066748

Fax the complete request

- Place the included fax cover on top.
- Fax the completed referral form and all supporting records to Molina at (833) 305-3130.
- Keep the fax confirmation page in the member's medical record.

Coast Care may help prepare administrative information, but the treating clinician remains responsible for clinical judgment, clinical documentation, and certification when required.

Molina Community Supports Fax Cover

Personal Care and Homemaker Services

To	Molina Healthcare UM Prior Authorization
Fax	(833) 305-3130
Date	
Total pages including cover	
Member name	
Member date of birth	
Medi-Cal CIN	
From treating provider	
Provider phone	
Provider fax	

Requested Community Supports Provider

Coast Care

NPI 1689066748

Documents included

- Completed Molina Community Supports referral form
- Supporting clinical and functional records
- Other applicable records listed in the referral form

This package contains 9 pages before any additional clinical records are attached.

Confidentiality notice

This fax may contain protected health information. It is intended only for the person or organization listed above. If you received it by mistake, please notify the sender and securely destroy it.

Personal Care and Homemaker Services Community Supports (CS) supports members who need assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs).

Submit completed form and supporting documentation to the UM Prior Authorization fax (833) 305-3130.

All fields with an * are required.

SECTION 1 – REFERRAL INFORMATION

Referral Date	
Referral Type	☐ Community Referral ☐ Identified by Molina ☐ Self-Referral ☐ Other:
Referring Organization Name	
Referring Organization NPI	
Referring Individual First Name*	
Referring Individual Last Name*	
Referring Individual Relationship to Member*	
Referring Individual Phone Number*	
Referring Individual Fax Number*	
Referring Individual Email Address*	

SECTION 2 – MEMBER INFORMATION

Member First Name*	
Member Last Name*	
Date of Birth*	
Medi-Cal CIN	
Preferred Written Language	
Member Email Address	
Member Primary Phone Number	
Member Residential Address	
City	
State	
Zip Code	

Is the member currently experiencing homelessness?	☐ Yes ☐ No ☐ Unknown

SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION

Member has Authorized Representative	☐ Yes ☐ No
Authorized Representative First Name	
Authorized Representative Last Name	
Authorized Representative Relationship to Member	
Phone Number	
Email Address	
Mailing Address	

SECTION 4 – CLINICAL INFORMATION

Primary Diagnosis	
ICD-10 Code	
Secondary Diagnoses	
Primary Care Provider	
Behavioral Health Provider (if applicable)	
Recent Hospitalization Within Past 30 Days	☐ Yes ☐ No
If Yes, Discharge Date	

SECTION 5 – SERVICE INFORMATION

Request Information

Service Start Date:

Service End Date:

Eligibility Criteria**Molina Enrollment:**☐ Enrolled in Medi-Cal with Molina**Member must meet one of the following:**☐ Member needs assistance with Activities of Daily Living (ADLs) and/or Instrumental Activity of Daily Living (IADL) tasks and has no other adequate support system.**OR**☐ Member is at risk for hospitalization or institutionalization in a nursing facility.**AND meet one of the following:**☐ Member was referred for IHSS and is searching for a caregiver through the Public Authority registry.**IHSS Referral Date:** **OR**☐ Member currently receives IHSS and needs additional IHSS hours. The reassessment request is pending and a caregiver is needed for support in the meantime.**Reassessment Request Date:** **IHSS Hours Per Month:** **OR**☐ Member is not eligible for IHSS and needs services to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).**Provide the IHSS Notice of Action indicating denial if available.**

Caregiver Support Preferences**Preferred Time for Caregiver Support:** ☐ Morning ☐ Afternoon ☐ No Preference**Total Hours Requested:**

Functional Needs Assessment**What are the member's physical limitations?**

Activities of Daily Living (ADLs)

ADL	Independent	Needs Assistance	Dependent
Ambulation	☐	☐	☐
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Self-Feeding	☐	☐	☐
Toileting	☐	☐	☐
Transferring	☐	☐	☐

Continence Information
☐ Continent

☐ Incontinent of Bladder: ☐ Occasionally ☐ Frequently ☐ Always

☐ Incontinent of Bowel: ☐ Occasionally ☐ Frequently ☐ Always

☐ External/Internal Catheter

☐ Ostomy

☐ Other:

Medical Conditions:**What does the member need assistance with (bathing, cooking, housekeeping, shopping, meal preparation, etc.)?****Does the member have additional assistance from family or friends?** ☐ Yes ☐ No

Does the member live alone? ☐ Yes ☐ No

Does the member have pets in the home? ☐ Yes ☐ No

Other Needs/Requests (i.e., Hoyer lift, male caregiver, language preference, etc.):

Special Instructions to Enter Residence:**Scheduling Contact****Scheduling Contact Name (if different from member/authorized representative):****Relationship to Member:****Phone Number:****SECTION 6 – REQUIRED DOCUMENTATION**

Please attach all supporting documentation required for review.

- ☐ IHSS Referral Documentation (if applicable)
- ☐ IHSS Reassessment Request Documentation (if applicable)
- ☐ IHSS Notice of Action Denial (if applicable)
- ☐ Supporting Clinical Documentation
- ☐ Additional Supporting Documentation

SECTION 7 – ATTESTATION**Member Consent**

- ☐ I attest that the member and/or authorized representative has consented to this Community Supports referral.

Referral Attestation

- ☐ I attest that the information provided in this referral is accurate and complete to the best of my knowledge.