

Caregiver Respite Services Patient Guide

For **Molina Healthcare** members and their caregivers

What is Caregiver Respite Services for

This service gives your main unpaid caregiver a short break. A different caregiver helps you during that time. The goal is to help you stay safe at home and avoid needing care in a facility.

Who may qualify

- You live at home and need help or supervision with daily activities.
- You depend on a caregiver for most of your support.
- Your caregiver needs a temporary break so they can continue caring for you.

Respite is temporary and is not a permanent caregiving plan. 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 caregiver respite 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 caregiver respite 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 help you need with daily activities, why your main caregiver needs a break, 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 Caregiver Respite Services through Molina's Community Supports benefit. My main caregiver needs relief so I can continue living safely 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.
- The name of your main caregiver and the number of hours they usually help you each week.
- The name of the different person who may provide the respite care.
- Any IHSS, Regional Center, hospital, or emergency room papers that apply.

Important information about respite

The caregivers must be two different people

The primary caregiver is the person who needs a break. The proposed respite caregiver is the different person who will provide care during that break.

Tell your provider about other respite services

Share any respite hours received this calendar year and whether another program or agency is also providing respite.

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 Caregiver Respite 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 lives in the community and depends on a qualified caregiver for ADL support.
- Explain why the caregiver who provides most of the support needs relief to help avoid institutional placement.
- Identify the current caregiver and the different proposed respite caregiver.
- Document current or prior IHSS, Regional Center, or other respite services and total respite hours received this calendar year.

Attach supporting records

- Clinical records supporting medical need, ADL dependency, or functional limitations.
- Records supporting caregiver burden and the need for caregiver relief.
- Hospital, emergency department, IHSS, or Regional Center records, when applicable.

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

Caregiver Respite 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 10 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.

Community Supports (CS) Caregiver Respite Services are provided to caregivers when it is useful and necessary to maintain a member in their own home and to preempt caregiver burnout to avoid institutional services. The services are provided on a short-term basis because of the absence or need for relief for the caregiver and are non-medical in nature. This service is rest for the caregiver only and only to avoid Long-Term Care placements.

The combination of all services the member is receiving cannot exceed 24 hours per day of care.

Send the completed referral via fax to: (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	Coast Care
Referring Organization NPI	1689066748
Referring Individual First Name*	
Referring Individual Last Name*	
Referring Individual Relationship to Member*	COM
Referring Individual Phone Number*	8582850938
Referring Individual Email Address*	calaim@coastcare.org

SECTION 2 – MEMBER INFORMATION

Member First Name*	
Member Last Name*	
Date of Birth*	
Medi-Cal CIN	
Preferred Written Language	
Member Email Address	N/A
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 pathways*:**Adult Caregiver Respite Eligibility****Member must meet BOTH:**

☒ Member lives in the community and is compromised in 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

Pediatric Palliative Care Eligibility

☐ Member is a child who previously received Caregiver Respite Services under the Pediatric Palliative Care Waiver.

Existing Caregiver Information

Is the member currently receiving In-Home Supportive Services (IHSS)*? ☐ Yes ☐ No

If not currently receiving IHSS, has the member applied for IHSS*? ☐ Yes ☐ No

Was IHSS applied for and denied*? ☐ Yes ☐ No

Is the member ineligible for IHSS services*? ☐ Yes ☐ No

If member has an existing IHSS caregiver, provide caregiver name and authorized hours:

Current Caregiver Name:

Current Caregiver Relationship to Member:

Proposed Respite Caregiver Name:

Proposed Respite Caregiver Relationship to Member:

Does the proposed respite caregiver currently live with the member? ☐ Yes ☐ No

Proposed Caregiver Respite Start Date:

Proposed Caregiver Respite End Date:

Caregiver Total Weekly Hours:

Need for Caregiver Respite Services

Please describe the circumstances causing the need for Caregiver Respite Services*:

Prior Caregiver Respite Utilization

☐ Member previously received Caregiver Respite Services during the current calendar year.

Is member receiving Caregiver Respite Services through another program or vendor (e.g., Regional Center)*?

☐ Yes ☐ No

Total Caregiver Respite Hours Received to Date:

Member Care Needs

Can the member administer their own medications*? ☐ Yes ☐ No

Hospital Stay or Emergency Department Visit within the last 30 days*? ☐ Yes ☐ No

Does the member have elopement or wandering behavior requiring continuous monitoring*? ☐ Yes ☐ No

Does the member have difficulty chewing and/or swallowing*? ☐ Yes ☐ No

Activities of Daily Living (ADLs)*

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

Current Assistive / Adaptive Devices*

☐ None

☐ Walker

☐ Wheelchair

☐ Cane

- ☐ Crutches
- ☐ Hearing Device
- ☐ Dentures
- ☐ Glasses or Other Vision Aids
- ☐ Communication (AAC) Device
- ☐ Specialized Eating Equipment / Utensils
- ☐ Orthosis / Prosthesis
- ☐ Gait Belt
- ☐ Hoyer Lift
- ☐ Respiratory Equipment
- ☐ Other:

Continence Information*

- ☐ Continent
- ☐ Incontinent of Bladder: ☐ Occasionally ☐ Frequently ☐ Always
- ☐ Incontinent of Bowel: ☐ Occasionally ☐ Frequently ☐ Always
- ☐ External/Internal Catheter
- ☐ Ostomy
- ☐ Other:

SECTION 6 – REQUIRED DOCUMENTATION

Please attach all supporting documentation required for review.

- ☐ Clinical Documentation Supporting Medical Necessity (if available)
- ☐ Documentation Supporting ADL Dependency or Functional Limitations
- ☐ Hospital Discharge Summary (if applicable)
- ☐ Emergency Department Documentation (if applicable)
- ☐ IHSS Documentation (if applicable)
- ☐ IHSS Notice of Action (if applicable)
- ☐ Regional Center Documentation (if applicable)
- ☐ Documentation Supporting Caregiver Burden and Need for Caregiver Respite Services

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.

☐ I attest that the member has not received more than 336 hours of Community Supports Caregiver Respite Services during the current calendar year.