Cal MediConnect Respite Care Referral Form

Fax or email the completed form to the Health Net* Public Programs Department at:
1-866-922-0783
Help_Referral@healthnet.com

Referral Information:

Date of referral:	Member ID #:	Date of birth:
Name:		Telephone number:
Address:		
Primary medical doctor's name and telephone #:		
Referring person's name and telephone #:		

Provide the Following Information:

Member's diagnosis(s): _____

_____

_____

_____

Height: _____ Weight: _____

Name of caregiver who needs respite care: _____ Telephone #: _____

Indicate How Many Hours and Specify Which Dates Respite is Needed:

(Up to a total of 24 hours of care within a six-month period; a minimum of four hours for each visit)

Date (example: 11/21/2017)	Hours (example: 4.0)	Time (example: 4:00 p.m. -8:00 p.m.)

Case Manager Information:

Case manager name:	Case manager contact information:

Reasons for Referral: **Provide which tasks are being requested** (services not included: transportation and housekeeping) *example: Assistance with meal prep, bathing, dressing*

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Note: If you need assistance filling out this form, please call 1-800-526-1898.

Health Net USE ONLY (For use only by the Public Programs Department)		
PPS Dept. original received date:	Type: ☐Expedited ☐Routine	Referral ID: