



**CS Asthma Remediation  
All Counties**

**Asthma Remediation is a Community Supports (CS) that can assist members by identifying, coordinating, or funding services and modifications necessary to a home environment to ensure the health, welfare, and safety of the member or to enable the member to function in the home without acute asthma episodes, which could result in the need for emergency services and hospitalization.**

**This referral must be signed off by a licensed health care professional. Submission of this referral is an attestation that Asthma Remediation services will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.**

Send completed referral via secure email: MHC\_CS@MolinaHealthcare.com or fax to: (833) 908-4424.

<b>Eligibility Criteria:</b>
Molina Enrollment: <input type="checkbox"/> Only Medi-Cal <input type="checkbox"/> Partial Duals Only: Medi-Cal with Medicare Part B and/or D
<b>Member must meet one of the two (2) following criteria:</b>
<input type="checkbox"/> Member had an emergency department visit or hospitalization OR two PCP or urgent care visits in the past 12 months due to asthma-related complications.
<input type="checkbox"/> Member scored 19 or lower on an Asthma Control Test. Attach scored test results.
<input type="checkbox"/> Member is not receiving duplicative support from other State, local, or federally funded programs.
<input type="checkbox"/> Member consented to Asthma Remediation referral and acknowledges once in a lifetime restriction.

<b>Licensed Health Care Professional:</b>
Name: _____ Credentials: _____
Hospital/SNF/Clinic/Office/FQHC Name: _____
Professional License Number: _____
Signature: _____ Date: _____

<b>Requestor Information:</b>
Last Member Contact: _____
Referrer: <input type="checkbox"/> Hospital/SNF <input type="checkbox"/> PCP/Clinic <input type="checkbox"/> IPA <input type="checkbox"/> ECM <input type="checkbox"/> Molina CM <input type="checkbox"/> Other:
Referrer Organization Name: _____
Referrer Name: _____ Title: _____
Referrer Phone Number: _____ Fax Number: _____

<b>Member Information:</b>
Member Name: _____ DOB: _____
Medi-Cal ID: _____ Preferred Language: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____
Alternate Contact Name: _____ Phone #: _____

If member has previously received Asthma Remediation Community Supports services, please include information explaining how the member’s condition has changed so significantly that additional modifications are necessary.