

CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

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MEDICAL/CLINICAL GUIDELINES

California Department of Corrections and Rehabilitation (CDCR) Reentry Programs (REPS) consist of the Male to Community Reentry Program (MCRP) and Custody to Female Community Reentry Program (FCRP). These populations, while no longer under correctional oversight, remain under the responsibility and oversight of the California Correctional Health Care Services (CCHCS) for their healthcare needs. As such, Community Health Care providers must follow policies and guidelines established by CCHCS when treating CDCR patients.

A. MEDICAL NECESSITY

Medical care provided to CDCR Reentry Programs (REPS) patients shall be aligned with Title 15. According to Title 15, **medical necessity** is defined as health care services determined by the attending physician to be reasonable and necessary to protect life, prevent premature death, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data as being effective medical care.

Title 15 Exclusions

- (1) Conditions that improve on their own without treatment.
- (2) Conditions that are not readily amenable to treatment, including, but not limited to, those which may be made worse by treatment with conventional medication or surgery, and those that are so advanced in the disease process that the outcome would not change with existing conventional or heroic treatment regimens.
- (3) Conditions that are cosmetic.
- (4) Surgery not medically necessary shall not be provided.
- (5) Services that have no established outcome on morbidity or improved mortality for acute health conditions shall not be provided.

(See Appendix A for the full list of Title 15 exclusions.)

B. INITIATING PRIMARY CARE

Upon the patient's initial visit to a primary care provider, the provider shall have the patient complete a CDCR-7385 form for *Authorization for Release of Protected Health Information (ROI)*. This form will allow the patient's medical records to be released from the CCHCS Health Records Center (HRC) and provide to the patient's primary care provider. The completed ROI form can be faxed to (916) 229-0002 or (916) 229-0608 or emailed to releaseofinformation@cdcr.ca.gov. *(See Appendix H for Mailing Instructions for the Health Records Center (HRC).)* Non-urgent ROI requests may take up to 14 days to be received by the requesting provider.

C. ROUTINE HEALTHCARE APPOINTMENTS

Patients shall be seen for an initial appointment upon arrival to the REPS facilities with a Primary Care Provider (PCP), in order to establish care. Patients do not need prior approval for this initial visit, with the exception of appointments for Medication Assisted Treatment (MAT). All follow up visits and/or new occurrences will require an approved REPS Healthcare Appointment Request Form *(See Appendix M)*.

D. COORDINATING SPECIALTY CARE WITH CCHCS REPS CLINICAL CARE TEAM

Explain to the patient that health care referrals, non-formulary medications, and Durable Medical Equipment (DME) will be reviewed by the CCHCS REPS Clinical Care Team. These services require special approval and shall not be performed without prior authorization. Refrain from using the following language, "I will order ..." (contracting providers may only order after a prior authorization has been approved). Providers should not make any guarantees for services or treatment.

When communicating medical issues and plans of care to patients, providers should emphasize that they will make recommendations to the REPS Physician Advisor (PA) and together decide on the best plan of care. This will help to diminish any incidence of staff-splitting behavior from the patient. When recommending medications, laboratory tests, procedures, diagnostics, or follow-up, be as specific as possible and follow the *Specialty and Non-Formulary Referrals* section of this document.

Urgent medical concerns should be discussed directly via telephone or email with the REPS Clinical Care Team. *(See Administrative Section C for the CCHCS REPS Contacts.)*



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E. SPECIALTY AND NON-FORMULARY REFERRALS

Specialty services shall be requested by the Primary Care Provider (PCP) who provided care in the community. The PCP shall inform the patient of the plan for specialty referral, document the plan in the health record, and notify the patient of any revisions to the plan. The requesting provider shall complete a Reentry Service Request (RSR) form for each specialty service desired and indicate the urgency and time frame in which the service is necessary.

Medically necessary specialty referrals for consultation and procedures shall be routed to the REPS Medical Mailbox at CDRCCHCSREPSMedical@cdcr.ca.gov for review and prior authorization by the REPS Physician Advisor (PA). If a patient requires a specialty consult, specialty procedure, non-formulary or high-cost medication, DME, Medication Assisted Treatment (MAT), or any imaging studies other than basic x-rays, an RSR form and supporting documentation must be sent via encrypted email to CDRCCHCSREPSMedical@cdcr.ca.gov.

All medical records for the referred patient must be sent overnight to the CCHCS Health Records Center, in order for the REPS Physician Advisor (PA) to review the records and make an informed decision. Please see the *CCHCS Receipt of Health Care Records* for more information.

After submission of the referral request, the PCP must follow the patient as determined necessary by the PCP until the specialist appointment occurs in order to follow the status of the patient's clinical condition and to initiate medically necessary services based on the status of the condition.

F. PRIOR AUTHORIZATION PROCESS*

**Emergent requests are exempt from the prior authorization referral request process. However, a referral request shall be submitted, after the fact, for retrospective tracking of emergent requests.*

1. Specialty and Non-Formulary

Upon receipt of the specialty or non-formulary referral, the medical documentation will be reviewed by the REPS PA. The review will be based on evidence-based clinical decision support criteria (InterQual). Some services, i.e. Hysterectomies, Hepatitis C treatment, etc., may require a third level review [CCHCS Statewide Medical Authorization Team (SMART) Committee]. All urgent requests will be reviewed and followed up with a response within two (2) business days. All routine requests will be reviewed with a response within seven (7) business days, with the exception of the third-level reviews. Third-level reviews will be responded to within sixty (60) business days.

Notification of request decision will be through the REPS Medical Mailbox to the original requestor or faxed back to the requesting provider. If the request is approved**, the PCP will then notify the patient of the decision and schedule services with a contracted CCHCS provider. If a contracted provider is not in the network, the PCP may refer to their specialty provider of choice or contact the REPS Admin Team at CDRCCHCSREPSAdmin@cdcr.ca.gov for assistance. If a request is denied, the PCP shall come up with an alternative treatment plan for the patient and notify the patient.

2. Routine Healthcare

Upon receipt of the REPS Healthcare Appointment Request Form, it will be reviewed by the REPS PA. Responses to all appointment requests will be sent within two (2) business days. It is the providers' responsibility to verify if the appointment has an approved form. Any appointments without an approved form, with the exception of urgent/emergent needs, will be denied payment.

Any denied requests shall not be performed and will not be paid for by CCHCS.

***Please note, an approved RSR form and/or Healthcare Appointment Request form is only valid during the patient's eligible timeframe. Should the patient leave the REPS program these forms are no longer valid and do not guarantee payment.*

G. CONSENTS AND REFUSALS

Discuss and document the risks and benefits of treatment as well as the risks of refusal if treatment is medically necessary. The surgeon performing the surgery should be the one to obtain consent from the patient. Patients have a right to refuse service. In such situations, complete the Refusal of Examination and/or Treatment Form (See Appendix K), have the patient sign and send to the HRC with the patient's medical records.



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H. INPATIENT HOSPITAL CASE MANAGEMENT

Hospital case managers and administrators will need to communicate information to CDCR regarding inpatients through the REPS Correctional Counselor III (CC III), as well as, send an email to the REPS Medical Mailbox.

REPS facilities do not provide medical services in-house, therefore any patient that requires more care than can be provided in an independent living home type facility should be referred back to the REPS Medical Mailbox for care coordination and placement at an appropriate level of care.

I. RADIOLOGY SERVICE REQUESTS FOR PLAIN X-RAYS

Primary care providers are not required to submit an RSR form nor obtain prior approval for plain x-rays. All other radiology requests will continue to require an RSR form for approval.

J. PHYSICAL THERAPY SERVICES MEDICAL NECESSITY

Physical Therapy is not routinely provided service for this patient population. Providers shall review and discern whether patients can do their Activities of Daily Living (ADL) such as feeding, bathing, grooming, and walking to programming.

If the patient cannot do their ADLs and is in need of physical therapy services, the provider must complete an RSR form for review and approval. Should the services not be available in the community, the patient's CC III and REPS PA will arrange for the patient to return to the institution or reassess.

If the patient can perform their ADLs, physical therapy is not a medical necessity.

K. VISION

Basic optometry services, including eye exams and glasses are a covered benefit and do not require an RSR form. Frame and lens purchases must have prior authorization from CCHCS for payment to be approved. Contact lenses are not a covered benefit, unless deemed a medical necessity by the REPS Clinical Care Team.

L. HEPATITIS C VIRUS (HCV) TREATMENT

Hepatitis C Treatment must follow the CCHCS HCV Treatment Care Guide. The CCHCS HCV Treatment Care Guide is available at <https://cchcs.ca.gov/clinical-resources/>. Providers must review the Care Guide, complete the Treatment Selection Review (TSR) form (Appendix E), and an RSR form (Appendix B). All documents must be sent to the REPS Medical Mailbox for review.

M. DIETARY SERVICES

Dietary services are not a covered benefit. Patients requiring specific dietary needs must inform the program CC III and the REPS Clinical Care Team for further action.

N. LOWER BUNK ACCOMMODATIONS

Lower bunk accommodations are not a covered benefit. Should a patient request or need a lower bunk within their housing facility, provider shall notify the program CC III and the REPS Clinical Care Team for further action.

O. PAYMENT

CCHCS is the obligatory payor for any approved healthcare services for REPS patients. Patients may not pay for any services out-of-pocket, nor can any other form of payment be used (i.e. private insurance, etc.) Additionally, any services performed without authorization may be denied payment.

FORMULARIES



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A. MEDICATION FORMULARIES

Providers must adhere to the CDCR/CCHCS formulary as much as possible. The CDCR/CCHCS formulary is available at www.cchcs.ca.gov. Non-formulary medication approval must go through the same *Prior Authorization Process* to obtain approval.

Mental health treatment and medications are to be provided solely by the CDCR Division of Adult Paroles (DAPO) Behavioral Health & Reintegration (BHR) Program. Mental health medications are to be prescribed and approved by authorized BHR physicians only. For mental health medications, providers must adhere to the DAPO Formulary available at <https://www.dgs.ca.gov/PD/About/Page-Content/PD-Branch-Intro-Accordion-List/Acquisitions/Statewide-Pharmaceutical-Program>. Any mental health non-formulary medication must be reviewed and approved by a CCHCS Clinician.

B. MEDICATION ASSISTED TREATMENT (MAT)

MAT for patients shall follow the *Prior Authorization Process*. Providers must complete an RSR form for these services and specify the treatment plan requested. RSR forms will be reviewed by the REPS Clinical Care Team for approval. Providers can refer to the Substance Use Disorder Guidelines located at <https://cchcs.ca.gov/clinical-resources/>. (See *Appendix I for the REPS MAT Provider Directory*.)

Should the patient wish to discontinue MAT services, the patient must work with their MAT provider to establish a discontinuation plan.

C. GABAPENTIN NON-FORMULARY PHARMACY REQUESTS

Gabapentin is considered a Non-Formulary medication. Prescriptions for Gabapentin require an RSR form and prior approval, regardless of dosage or transmission method (pill or solution).

An RSR form must be submitted to the REPS Clinical Care Team for review in accordance with the *Prior Authorization Process*.

D. OVER-THE-COUNTER (OTC) MEDICATIONS AND PRODUCTS NON-FORMULARY PHARMACY REQUESTS

OTC medications and products are considered non-formulary and require an RSR form and prior authorization, in accordance with the *Prior Authorization Process*.

Only medications and/or products on the OTC Products List are exempt from requiring an RSR form and prior authorization. (See *Appendix L for the OTC Products List*.)

E. DURABLE MEDICAL EQUIPMENT (DME)

Providers are expected to adhere to the CCHCS DME and Medical Supply Formulary. All DME must follow the *Prior Authorization Process* to obtain approval prior to ordering the DME. The CCHCS DME formulary is available at <https://cchcs.ca.gov/wp-content/uploads/sites/60/PR/DME-Medical-Supply-Formulary.pdf>. CCHCS will order and purchase all approved DME through the Department's Acquisitions Management Section.

MENTAL HEALTH GUIDELINES

A. BEHAVIORAL HEALTH & REINTEGRATION (BHR) PROGRAM

Patients seeking mental health services are to be referred to the Division of Adult Parole Operations (DAPO), Behavioral Health & Reintegration (BHR) Program. The BHR Program locations serve patients in the Northern and Southern Regions of the State and can accommodate all of the REPS patients' mental health needs. BHR is the only program authorized to render mental health services to REPS patients.

(See *Appendix J for the BHR Contacts & Locations*.)

B. MENTAL HEALTH MEDICATION FORMULARY

BHR providers must adhere to the CDCR formulary and the DAPO formulary as much as possible. The CDCR



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formulary is available at www.cchcs.ca.gov. The DAPO Formulary is available at <https://www.dgs.ca.gov/PD/About/Page-Content/PD-Branch-Intro-Accordion-List/Acquisitions/Statewide-Pharmaceutical-Program>. Any mental health non-formulary medication must be reviewed and approved by a CCHCS Clinician.

DENTAL GUIDELINES

A. PURPOSE

The purpose of the REPS Dental Program is to provide quality clinical dental services in a professional and efficient manner to those eligible for care while housed at a REPS facility. The following will act as a guide to policies and procedures set by CDCR, Adult Correctional Dental Care (ACDC).

B. PROCEDURE

Services will be based on established priorities as listed in the CCHCS Reentry Programs Dental Fee Schedule

C. INITIATING PRIMARY DENTAL CARE

Upon the patient's initial visit to a dental provider, the provider shall have the patient complete a CDCR-7385 form for *Authorization for Release of Protected Health Information (ROI)*. This form will allow the patient's dental records to be released from the CCHCS Health Records Center (HRC) and be provided to the patient's primary dental provider. The completed ROI form can be faxed to (916) 229-0002 or (916) 229-0608 or emailed to releaseofinformation@cdcr.ca.gov. (See Appendix F for the ROI form and instructions.) Non-urgent ROI requests may take up to 14 days to be received by the requesting provider.

D. REFERRALS

The patient's primary dental provider will also serve as a referral center. Referrals to dental specialty care shall be based on established priorities, approvals, program exclusions, clinical necessity, and available resources. Referrals must be completed on a Reentry Dental Service Request (RDSR) Form (See Appendix C) and emailed to CDCRCCHCSREPSDental@cdcr.ca.gov referrals must have prior authorization. Claims received without prior authorization will be denied for payment.

E. PLAN EXCLUSIONS AND LIMITATIONS

Some Services Not Covered Under the Plan Are:

1. Services or supplies that are covered in whole or in part under any other part of the REPS program.
2. Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
3. Those for plastic, reconstructive, or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
4. Those for or in connection with services, procedures, drugs or other supplies that are determined to be experimental or still under clinical investigation by health professionals.
5. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
6. Services that REPS Dental Program defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician or dentist.
7. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified "By Report."
8. Those for orthodontic treatment.
9. Those for general anesthesia and intravenous sedation.
10. Those for treatment by other than a dentist, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist as well as topical application of fluoride. In this case, the treatment must be given under the supervision and guidance of a dentist.
11. Services needed solely in connection with non-covered services.
12. Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventative services.



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F. OTHER IMPORTANT INFORMATION

This benefits summary of the REPS Dental Program provides information on benefits provided when a contracted provider renders services. In order for a person to be eligible for benefits, a primary care dentist selected from the network of contracted dentists must provide the dental services unless otherwise approved and authorized by the CCHCS REPS Administration.

G. SPECIALTY REFERRALS

Under the REPS dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by the REPS Dental Program. Payment to the specialty dentist is based on a negotiated fee for which the member does not have a copayment for the service(s) under this plan.

Orthodontic services are excluded under this program.

H. EMERGENCY DENTAL CARE

If emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency is needed, coverage must be made available 24 hours a day, 7 days a week.

I. REPS DENTAL PLAN COVERAGE RULES

REPS Dental Plan coverage is subject to the following rules:

1. REPLACEMENT RULE: The replacement of, addition to, or modification of an existing denture, removable partial denture, or other prosthetic appliance is covered only if **one** of the following terms is met:
 - a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture, removable partial denture, or other prosthetic appliance was originally delivered.
 - b. The existing denture, removable partial denture, or other prosthetic appliance cannot be made serviceable, and was delivered at least 5 years before its current need for replacement.
2. ALTERNATE TREATMENT RULE: If more than one service can be used to treat an eligible person's dental condition, REPS Dental Program may decide to authorize coverage only for a less costly covered service provided that **all** of the following terms are met:
 - a. The service must be listed on the CCHCS REPS Dental Fee Schedule;
 - b. The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
 - c. The services selected must meet broadly accepted national standards of dental practice.



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ADMINISTRATIVE

A. AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (ROI) FORM INSTRUCTIONS

Upon initial visit with a REPS patient, the PCP is to have the patient complete a CDCR-7385 form for *Authorization for Release of Protected Health Information (ROI)* form. The PCP and the patient must complete all parts of the ROI form. All sections must be completed for the authorization to be honored. Use "N/A" if not applicable. Detailed instructions are on pages 3 & 4 of the CDCR-7385 form.

- Indicate type of documents needed (Part V) Medical Services, Dental Services or Other. *Please note if the PCP is requesting all medical records for the patient, delivery could take up to 14 business days.*
- If the request is urgent, the turnaround time is 24 – 48 business hours.
- Authorization must be signed by the patient. If the Authorization is not signed by the patient, the request will be rejected.

The PCP must fax or email the completed ROI form to the contacts below:

- Fax: (916) 229-0002 or (916) 229-0608
- E-Mail: releaseofinformation@cdcr.ca.gov

If you have any questions regarding these instructions please contact the CCHCS REPS Help Desk:

- Phone: (916) 691-0699
- E-Mail: CDCRCCHCSREPSAdmin@cdcr.ca.gov

B. CCHCS RECEIPT OF HEALTH CARE RECORDS

Providers must mail all health care records to the CCHCS Health Record Center (HRC) via General Logistics Systems (GLS) within 48 hours of the patient encounter. This ensures that CCHCS Utilization Management has all of the necessary documentation regarding a patient's medical needs and allows for a thorough review and decision. Providers shall not send the documents by portable medium, e.g., CD, DVD, USB flash drive, etc. All documents must be sent in hard copy via GLS. See *Appendix H, Mailing Instructions for the Health Records Center (HRC)* section for detailed instructions on how to mail health care documentation to CCHCS for REPS patients. A delay in submittal of these records could affect claims payment.

C. CCHCS REPS CONTACTS

Medical Team

Reentry Service
Request (RSR)
Forms/Healthcare
Appointment
Request Forms

CDCRCCHCSREPSMedical@cdcr.ca.gov

Medical Questions

REPS Physician Jelena Nikolic, MD
Advisor

Dental Team

Treatment
Authorizations/
Referral Requests

CDCRCCHCSREPSDental@cdcr.ca.gov



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Appendix A

TITLE 15

ARTICLE 8: MEDICAL AND DENTAL SERVICES

3350. Provision of Medical Care and Definitions.

(a) The department shall only provide medical services for inmates, which are based on medical necessity and supported by outcome data as effective medical care. In the absence of available outcome data for a specific case, treatment will be based on the judgment of the physician that the treatment is considered effective for the purpose intended and is supported by diagnostic information and consultations with appropriate specialists. Treatments for conditions, which might otherwise be excluded, may be allowed pursuant to section 3350.1(d).

(b) For the purposes of this article, the following definitions apply:

(1) Medically Necessary means health care services that are determined by the attending physician to be reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data as being effective medical care.

(2) Outcome Study means the definition, collection and analysis of comparable data, based on variations in treatment, concerning patient health assessment for purposes of improving outcomes and identifying cost-effective alternatives.

(3) Outcome Data mean statistics such as diagnoses, procedures, discharge status, length of hospital stay, morbidity and mortality of patients that are collected and evaluated using science-based methodologies and expert clinical judgment for purposes of outcome studies.

(4) Severe pain means a degree of discomfort that significantly disables the patient from reasonable independent function.

(5) Significant illness and disability means any medical condition that causes or may cause if left untreated a severe limitation of function or ability to perform the daily activities of life or that may cause premature death.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

HISTORY:

1. Repealer of Article 8 (Sections 3370–3372) and new Article 8 (Sections 3350–3359) filed 4-18-80; effective thirtieth day thereafter (Register 80, No. 16). For prior history see Register 77, No. 9.

2. Amendment of article heading, section heading and text filed 7-2-93; operative 8-2-93 (Register 93, No. 27).

3. Amendment of section heading, relocation of subsections 3350(a)–(c) to 3350.2(a)–(c), and new Subsections (a)–(b)(3) filed 2-17-95 as an emergency; operative 3-1-95 (Register 95, No. 9). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 8-8-95 or emergency language will be repealed by operation of law on the following day.

4. Amendment refiled 8-7-95 as an emergency; operative 8-7-95 (Register 95, No. 32). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 1-16-96 or emergency language will be repealed by operation of law on the following day.



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5. Reinstatement of section as it existed prior to emergency amendment filed 2-17-95 by operation of Government Code section 11346.1(f) (Register 96, No. 8).

6. Amendment of section heading, renumbering of subsections 3350(a)–(c) to 3350.2(a)–(c), and new subsections (a)–(b)(3) filed 2-21-96 as an emergency; operative 2-21-96 (Register 96, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-20-96 or emergency language will be repealed by operation of law on the following day.

7. Certificate of Compliance as to 2-21-96 order including amendment of subsection (a) and new subsections (b)(4) and (b)(5) transmitted to OAL 6-18-96 and filed 7-9-96 (Register 96, No. 28).

3350.1. Medical and Dental Treatment/Service Exclusions.

(a) Treatment refers to attempted curative treatment and does not preclude palliative therapies to alleviate serious debilitating conditions such as pain management and nutritional support. Treatment shall not be provided for the following conditions:

(1) Conditions that improve on their own without treatment. Examples include, but are not limited to:

- (A) Common cold.
- (B) Mononucleosis.
- (C) Viral hepatitis A.
- (D) Viral pharyngitis.
- (E) Mild sprains.
- (F) Benign oral lesions.
- (G) Traumatic oral ulcers.
- (H) Recurrent aphthous ulcer.

(2) Conditions that are not readily amenable to treatment, including, but not limited to, those which may be made worse by treatment with conventional medication or surgery, and those that are so advanced in the disease process that the outcome would not change with existing conventional or heroic treatment regimens. Examples include, but are not limited to:

- (A) Multiple organ transplants.
- (B) Temporomandibular joint dysfunction.
- (C) Grossly metastatic cancer.
- (D) Shrinkage and atrophy of the bony ridges of the jaws.
- (E) Benign root fragments whose removal would cause greater damage or trauma than if retained for observation.

(3) Conditions that are cosmetic. Examples include, but are not limited to:

- (A) Removal of tattoos.
- (B) Removal of nontoxic goiter.
- (C) Breast reduction or enlargement.
- (D) Penile implants.
- (E) Removal of existing body piercing metal or plastic rings or similar devices within the oral cavity, except for security reasons.
- (F) Restoration or replacement of teeth for esthetic reasons.
- (G) Restoration of any natural or artificial teeth with unauthorized biomaterials.

(b) Surgery not medically necessary shall not be provided. Examples include, but are not limited to:

- (1) Castration.
- (2) Vaginoplasty (except for Cystocele or Rectocele).
- (3) Vasectomy.
- (4) Tubal ligation.



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(5) Extractions of asymptomatic teeth or root fragments unless required for a dental prosthesis, or for the general health of the patient's mouth.

(6) Removal of a benign bony enlargement (torus) unless required for a dental prosthesis.

(7) Surgical extraction of asymptomatic un-erupted teeth.

(c) Services that have no established outcome on morbidity or improved mortality for acute health conditions shall not be provided. Examples include, but are not limited to:

(1) Acupuncture.

(2) Orthoptics.

(3) Pleoptics.

(4) Root canals on posterior teeth (bicuspid and molars).

(5) Dental Implants.

(6) Fixed prosthodontics (dental bridges).

(7) Laboratory processed crowns.

(8) Orthodontics.

(d) Treatment for those conditions that are excluded within these regulations may be provided in cases where all of the following criteria are met:

(1) The inmate's attending physician or dentist prescribes the treatment as clinically necessary.

(2) The service is approved by the Dental Authorization Review committee and the Dental Program Health Care Review Committee for dental treatment, or the Institutional Utilization Management committee and the Headquarters Utilization Management committee for medical treatment. The decision of the review committee, as applicable, to approve an otherwise excluded service shall be based on:

(A) Available health and dental care outcome data supporting the effectiveness of the services as medical or dental treatment.

(B) Other factors, such as:

1. Coexisting medical or dental problems.

2. Acuity.

3. Length of the inmate's sentence.

4. Availability of the service.

5. Cost.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; and *Perez, et al. v. Cate, et al.*, USDC no. 3:05-cv-05241-JSW (No. Cal.).

HISTORY:

1. New section, including relocation and amendment of old subsection 3354.1(a) to 3350.1(b), filed 2-17-95 as an emergency; operative 3-1-95 (Register 95, No. 9). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 8-8-95 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 8-7-95 as an emergency; operative 8-7-95 (Register 95, No. 32). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 1-16-96 or emergency language will be repealed by operation of law on the following day.

3. Reinstatement of section as it existed prior to emergency amendment filed 2-17-95 by operation of Government Code section 11346.1(f) (Register 96, No. 8).



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

4. New section, including renumbering and amendment of former subsection 3354.1(a) to 3350.1(b), filed 2-21-96 as an emergency; operative 2-21-96 (Register 96, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-20-96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 2-21-96 order including amendment of subsection (a), repealer of subsection (d)(2) and subsection renumbering, amendment of newly designated subsection (d)(2), repealer of newly designated subsection (d)(2)(A) and subsection relettering, and amendment of newly designated subsection (d)(2)(A) transmitted to OAL 6-18-96 and filed 7-9-96 (Register 96, No. 28).
6. Amendment of subsections (d)(1)–(d)(2)(A) and (d)(2)(B)1. filed 10-3-2006 as an emergency; operative 10-3-2006 (Register 2006, No. 40). Pursuant to Penal Code section 5058.3, a Certificate of Compliance must be transmitted to OAL by 3-12-2007 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 10-3-2006 order transmitted to OAL 3-7-2007 and filed 4-18-2007 (Register 2007, No. 16).
8. New subsections (a)(1)(F)–(H), (a)(2)(D)–(E), (a)(3)(E)–(G), (a)(5)–(7) and (c)(4)–(8) and amendment of subsections (d)(1)–(2) and Note filed 3-28-2012 as an emergency; operative 3-28-2012 (Register 2012, No. 13). Pursuant to Penal Code section 5058.3, a Certificate of Compliance must be transmitted to OAL by 9-4-2012 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 3-28-2012 order, including further amendment of subsection (d)(2), transmitted to OAL 9-4-2012 and filed 10-4-2012 (Register 2012, No. 40).



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix B



REENTRY (REPS) SERVICE REQUEST FORM

Email: CDCRCHCSREPSMedical@CDCR.ca.gov

<input type="checkbox"/> MCRP <input type="checkbox"/> FCRP <input type="checkbox"/> OTHER:		
Service is: <input type="checkbox"/> NON-URGENT <input type="checkbox"/> URGENT ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:
Referral/Service Type Requested		
<input type="checkbox"/> Specialist Consult/Tx/FU Care	<input type="checkbox"/> LOC Change	<input type="checkbox"/> Surgical Procedure
<input type="checkbox"/> Inpatient Admission	From _____ To _____	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
<input type="checkbox"/> Major Diagnostic Procedure	<input type="checkbox"/> Mental Health	Facility:
<input type="checkbox"/> Medication (non-formulary)	<input type="checkbox"/> Other:	Date of Service:
<input type="checkbox"/> DME (refer to PA list)	<input type="checkbox"/> Comments:	
Requesting Provider Information		Referring To Provider Information
Requesting Provider Name: (Last, First)		Referring To Provider Name: (Physician, mg.ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)		Address: (No., Street, City, State, Zip)
Specialty:		Specialty:
Phone Number:		Phone Number:
Fax Number:		Fax Number:
Service Request Information		
ICD-10 Code #/Description:	Code or Description:	
Clinical Indications for Request: (include pertinent past medical history, treatment, physical findings, and attach all relevant medical records and test results, etc.)		
Requesting Practitioner Signature:		Date:
CCHCS UM Staff Use Only		
Criteria/Guidelines Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization Status: <input type="checkbox"/> Approved <input type="checkbox"/> Deferred <input type="checkbox"/> Denied	
Comments:		
UM Representative Signature:		Date:
UM Review		
<input type="checkbox"/> APPROVED	COMMENTS:	
<input type="checkbox"/> MODIFIED		
<input type="checkbox"/> DENIED		
UM Physician's Signature:		Date:

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CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE

Version 4

May 2024



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix C



REENTRY (REPS) DENTAL SERVICE REQUEST FORM

Email: CDCRCHCSREPSDental@CDCR.ca.gov

<input type="checkbox"/> MCRP <input type="checkbox"/> FCRP <input type="checkbox"/> OTHER:		
Service is: <input type="checkbox"/> NON-URGENT <input type="checkbox"/> URGENT ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:
Referral/Service Type Requested		
<input type="checkbox"/> Alveoplasty	<input type="checkbox"/> Biopsy/Lesion	<input type="checkbox"/> Cyst/Tumor
<input type="checkbox"/> Extraction	<input type="checkbox"/> Incision and Drainage	<input type="checkbox"/> Infection
<input type="checkbox"/> Tori Removal	<input type="checkbox"/> Oral/Facial Trauma	<input type="checkbox"/> Other:
Requesting Provider Information		Referring To Provider Information
Requesting Provider Name: (Last, First)		Referring To Provider Name: (Physician, mg, ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)		Address: (No., Street, City, State, Zip)
Phone Number:		Phone Number:
Fax:		Fax:
Service Request Information		
Please Circle Teeth or Area to be Treated		
Comments or Concerns:		
Requesting Dentist's Signature:		Date:
CDCR/CCHCS Dental Services Review		
<input type="checkbox"/> APPROVED	COMMENTS:	
<input type="checkbox"/> MODIFIED		
<input type="checkbox"/> DENIED		
CDCR ACDC Reviewer Signature:		Date:

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CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE

May 2024



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix D

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507



TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, MI)		3. SEX M F		4. PATIENT BIRTHDATE MO DAY YR		5. MEDI-CAL BENEFITS ID CARD NUMBER	
6. PATIENT ADDRESS						7. PATIENT DENTAL RECORD NUMBER	
CITY, STATE				ZIP CODE		8. REFERRING PROVIDER NPI	
9. RADIOGRAPHS ATTACHED? CHECK IF YES HOW MANY? _____		11. ACCIDENT/INJURY? CHECK IF YES EMPLOYMENT RELATED? _____		13. OTHER DENTAL COVERAGE? CHECK IF YES 14. MEDICARE DENTAL COVERAGE? CHECK IF YES		16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF YES 17. CCS CALIFORNIA CHILDREN SERVICES? CHECK IF YES	
10. OTHER ATTACHMENTS? CHECK IF YES		12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) CHECK IF YES		15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) CHECK IF YES		18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? CHECK IF YES	
19. BILLING PROVIDER NAME (LAST, FIRST, MI)				20. BILLING PROVIDER NPI			
21. MAILING ADDRESS				TELEPHONE NUMBER			
CITY, STATE				ZIP CODE			
22. PLACE OF SERVICE OFFICE HOME CLINIC SNF ICF HOSPITAL IN-PATIENT HOSPITAL OUT-PATIENT OTHER (PLEASE SPECIFY)							
EXAMINATION AND TREATMENT							
26. TOOTH # (IR ARCH QUAD)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
34. COMMENTS						35. TOTAL FEE CHARGED	
						36. PATIENT SHARE-OF-COST AMOUNT	
						37. OTHER COVERAGE AMOUNT	
39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.						38. DATE BILLED	

BIC Issue Date: _____
EVC #: _____

X _____
SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form. The X-ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix E

HCV TREATMENT SELECTION REVIEW: QUESTIONNAIRE FOR MEDICATION SELECTION (Rev. 01/2021)			
Patient Last Name:	CDCR #:	Date Form Completed:	
<i>It is imperative that this patient be able to complete the entire HCV treatment course (typically 12 weeks) without any interruptions.</i>			
Release Date: <i>If <5 months, patient cannot complete tx prior to release and tx should not be started.</i>			
Does patient have ability to give informed consent and cooperate with treatment?			<input type="checkbox"/> Y <input type="checkbox"/> N
Have you documented that patient is not pregnant and is able to practice contraception?			<input type="checkbox"/> Y <input type="checkbox"/> N
Does patient have a life expectancy of less than 12 months? <i>Patient may not be a candidate for HCV treatment.</i>			<input type="checkbox"/> Y <input type="checkbox"/> N
Most recent FIB4 score:			
COMORBIDITIES / COMPLICATIONS - DOES THE PATIENT HAVE:			
History of cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	History of organ transplant?	<input type="checkbox"/> Y <input type="checkbox"/> N
GFR < 30 or Hemodialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	Known HIV co-infection?	<input type="checkbox"/> Y <input type="checkbox"/> N
Known HBV co-infection?	<input type="checkbox"/> Y <input type="checkbox"/> N	Any HCV extra-hepatic manifestations?	<input type="checkbox"/> Y <input type="checkbox"/> N
FIBROSIS STAGING STUDY			
<i>Most patients do not require a staging study. If patient's FIB4 score is 1.45-3.25 please order a Fibroscan ®.</i>			
Fibroscan® (kPa):		Fibroscan® Date:	
HCV TREATMENT HISTORY			
Has this patient had prior HCV treatment? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, provide: Treatment Year, Location, Regimen Used and Duration of Treatment in weeks:			
Response to Prior Treatment: <input type="checkbox"/> Null <input type="checkbox"/> Partial Responder <input type="checkbox"/> Relapse/Reinfection <input type="checkbox"/> SVR 12 achieved <input type="checkbox"/> Unknown <i>Critical to ensure appropriate medication selection and whether resistance testing is required prior to medication selection.</i>			
HCV GENOTYPE			
<i>Must be done within the past 12 months if patient has had prior treatment.</i>			
HCV Genotype Result:		HCV Genotype Date:	
If experienced and Genotype 1a, Order RAS testing Quest Code (92447). No results are required for submittal.			
HCV VIRAL LOAD			
HCV Viral load results:		HCV Viral load results Date:	
HEPATITIS B STATUS: MUST BE WITHIN PAST 12 MONTH			
<i>MANY patients require a Hepatitis Viral DNA level prior to treatment. Please carefully review Hepatitis B labs and order HBV DNA if indicated. Medication cannot be started without this information.</i>			
Hepatitis B surface ANTIGEN (HBsAg) Result:		Hepatitis B surface ANTIGEN (HBsAg) Date:	
Hepatitis B surface ANTIBODY (HBsAb) Result:		Hepatitis B surface ANTIBODY (HBsAb) Date:	
Hepatitis B Core ANTIBODY (HBcAb) Result:		Hepatitis B Core ANTIBODY (HBcAb) Date:	
HBV DNA REQUIRED ONLY IF: HBsAg positive OR HBcAb positive and HBsAb negative			
HBV DNA Result:		HBV DNA Date:	
LABS: MUST BE DONE WITHIN PAST 12 MONTHS			
HIV Result:		HIV Result Date:	
LABS: MUST BE DONE WITHIN THE PAST 3 MONTHS			
CBC Date:		CMP Date:	PT/INR Date:
CURRENT MEDICATION INFORMATION			
Medication Allergies:			
Is patient on any of the following medications?			
Oxcarbazepine	<input type="checkbox"/> Y <input type="checkbox"/> N	Carbamazepine	<input type="checkbox"/> Y <input type="checkbox"/> N
Phenobarbital	<input type="checkbox"/> Y <input type="checkbox"/> N	Rifampin	<input type="checkbox"/> Y <input type="checkbox"/> N
Phenytoin			<input type="checkbox"/> Y <input type="checkbox"/> N
Medication Selected/Duration:			
Special Instructions if any:			
CCHCS HQ HCV Oversight Provider (signature):		Date:	



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix F

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 05/25)

California Correctional Health Care Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Page 1 of 2

1. PATIENT INFORMATION				
Patient Name (Last, First)		Date of Birth	CDCR #	
2. PARTIES TO RECEIVE INFORMATION (SELECT ONE)				
<input type="checkbox"/> Patient <input type="checkbox"/> Person or Organization Name _____ Address: _____ City/State/Zip: _____ Email Address/Fax: _____ Phone Number: _____ <input type="checkbox"/> Federal, state, county, and community-based organizations (including service providers, care coordinators, and case management staff) coordinating pre-release, transition, and post-release services of patient care.				
3. PARTY TO RELEASE INFORMATION (SELECT ONE)				
<input type="checkbox"/> CDCR <input type="checkbox"/> Organization Name _____				
4. PURPOSE				
<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Friends or Family	<input type="checkbox"/> Legal	<input type="checkbox"/> Other (specify) _____
5. INFORMATION TO BE RELEASED				
A. Protected Health Information (select only 1, 2, or 3)				
<input type="checkbox"/> 1. All information related to my care <input type="checkbox"/> 2. The following information <input type="checkbox"/> Mental health information <input type="checkbox"/> Dental information <input type="checkbox"/> Medical information <input type="checkbox"/> Other information (specify) _____ <input type="checkbox"/> 3. Only HIV test results. I understand that HIV test results are released separate from other health care records. I agree that by checking this HIV test results box, I authorize the release of specially protected health information. A new authorization will be required for subsequent disclosures.				
B. Specially Protected Health Information (select if applicable)				
I understand the types of information below have extra confidentiality protections required by law. I would like the following specially protected health information released if it is in my record:				
<input type="checkbox"/> Regional center developmental disability service records for care provided outside CDCR ("DDS Services")				



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 05/25)

California Correctional Health Care Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Page 2 of 2

<input type="checkbox"/> Substance use treatment service records for care provided outside CDCR, including any services provided by a Narcotic Treatment Program ("Part 2 Program Services").	
C. Dates of Service (select one)	
<input type="checkbox"/> All dates of service	
<input type="checkbox"/> Only dates of service from (insert dates) _____ - _____	
6. METHOD OF RELEASE OF INFORMATION (SELECT ALL THAT APPLY)	
<input type="checkbox"/> Written or electronic records (e.g., facsimile, mail, CD)	
<input type="checkbox"/> Verbal or written correspondence (Note: This option is not available to patients who have paroled or discharged from CDCR.)	
7. EXPIRATION DATE	
This authorization will remain in effect as follows (select one):	
<input type="checkbox"/> This authorization shall remain in effect until revoked by the patient	
<input type="checkbox"/> This authorization expires one year from the date signed below	
<input type="checkbox"/> This authorization expires on the following date: _____	
8. RIGHTS	
I understand:	
<ul style="list-style-type: none"> ▪ I may refuse to sign this authorization; refusal will not affect my ability to obtain treatment. ▪ I may revoke this authorization at any time by providing written notification to California Correctional Health Care Services, Health Information Management Services. ▪ If I revoke this authorization, my revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid. ▪ I may request a copy of this signed form. ▪ Information disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be subject to federal and state privacy law protection. ▪ Even if I do not authorize a release of health information, CDCR may share my confidential information for treatment, payment, and health care operations and other purposes required or permitted by law. 	
9. SIGNATURES	
Signature of Patient/Agent	Date
Print Name of Patient/Agent	Relationship to Patient (If applicable)
<i>If you are the Agent, you must attach documentation of your authority to act on behalf of the patient.</i>	

DISTRIBUTION: Original: Health Records; Copies: Patient

EHR LOCATION: Administrative – Authorization for Release of Health Care Record; Authorization for Release of PHI



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix G

REQUEST FOR GSO SHIPPING LABELS

DATE: _____ BILLING CODE: 16071-REPS

DELIVER TO: _____
ADDRESS: _____
ATTENTION: _____
PHONE #: _____

FROM: _____
ADDRESS: _____
UNIT: _____
NAME: _____
PHONE #: _____

SEND EMAIL CONFIRMATION TO: CDCRCCHCSREPSAdmin@cdcr.ca.gov

COMMENTS/SPECIAL INSTRUCTIONS: _____
Please include an area on the label for the provider to include "Amount Per Package"

REQUEST FOR GSO SHIPPING LABELS

DATE: _____ BILLING CODE: 16071-REPS

DELIVER TO: _____
ADDRESS: _____
ATTENTION: _____
PHONE #: _____

FROM: _____
ADDRESS: _____
UNIT: _____
NAME: _____
PHONE #: _____

SEND EMAIL CONFIRMATION TO: CDCRCCHCSREPSAdmin@cdcr.ca.gov

COMMENTS/SPECIAL INSTRUCTIONS: _____
Please include an area on the label for the provider to include "Amount Per Package"



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix H

MAILING INSTRUCTIONS FOR THE HEALTH RECORDS CENTER (HRC)

1. Contracted health care providers who see any patient that is a part of the CCHCS Reentry Programs (REPS) are required to send all patient health care records from each encounter to the HRC within 48 hours.
2. California Correctional Health Care Services (CCHCS), Healthcare Invoicing Section (HIS) will provide pre-printed General Logistics Systems (GLS) shipping label(s) and packaging materials to the contracted health care provider on an as-needed basis.
3. If a provider runs out of GLS shipping labels or packaging, they must email the REPS Administrative Mailbox at CDCRCCHCSREPSAdmin@cdcr.ca.gov to request more.
4. When preparing the package for shipment please note the following:
 - Health care records may not be sent by portable medium (CD, DVD, USB flash drive, etc.)
 - Only health care documentation of REPS patients shall be sent to HRC.
 - GLS is to be the only shipping company to be used.
 - Ensure all documents sent to HRC have the correct Patient Identifiers such as: California Department of Corrections and Rehabilitation (CDCR) #, last name, first name and date of birth.
 - Note the tracking number for each package that is sent to HRC.
 - Handwrite the size of the records package in inches of thickness on the label.



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix I

CCHCS Reentry Programs (REPS) REFUSAL OF EXAMINATION AND / OR TREATMENT

REFUSAL OF EXAMINATION AND / OR TREATMENT		
PATIENT NAME (TYPE OR PRINT CLEARLY)	CDCR NUMBER	INSTITUTION

Having been fully informed of the risks and possible consequences involved in refusal of the examination and/or treatment in the manner and time prescribed for me, I nevertheless refuse to accept such examination and/or treatment. I agree to hold the Department of Corrections and Rehabilitation, the staff of the medical department and the institution free of any responsibility for injury or complications that may result from my refusal of this examination and/or treatment, specifically:

Describe the examination and/or treatment refused as well as the risks and benefit of the intervention:

PATIENT SIGNATURE	DATE	<input type="checkbox"/> PATIENT REFUSES TO SIGN	DATE
WITNESS			
NAME OF WITNESS (PRINT/TYPE)		NAME OF WITNESS (PRINT/TYPE)	
WITNESS SIGNATURE	DATE	WITNESS SIGNATURE	DATE

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state law.



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix J



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Over-The-Counter (OTC) Products List

The chart below details the specific OTC products approved for distribution:

OVER-THE-COUNTER PRODUCTS (MEDICATIONS)		
Indication	Category	Product Name
1. Gastrointestinal Reflux/Heartburn	Antacid	Aluminum Hydroxide/Magnesium Hydroxide/Simethicone
2. Gastrointestinal Reflux/Heartburn	H-2 Blocker	Ranitidine 150 mg
3. Allergy-Seasonal	Antihistamine	Loratadine 10 mg
4. Allergy-Seasonal	Antihistamine	Cetirizine 10 mg
5. Pain/Fever	NSAID	Naproxen 220 mg
6. Pain/Fever	NSAID	Ibuprofen 200 mg
7. Athletes Foot	Topical-Antifungal	Clotrimazole 1%
8. Skin Irritation	Topical-Steroid	Hydrocortisone 1%
*OVER-THE-COUNTER PRODUCTS (NON-MEDICATED COMFORT)		
Indication	Category	Product Name
9. Nasal Congestion	Nasal Moisturizer	Saline Nasal Spray
10. Dry Eyes	Eye Lubricant	Artificial Tears
11. Dry Skin	Topical-Lotion	Moisturizing Lotion
12. Sun Exposure	Topical-Sunscreen	Sunscreen Lotion SPF 30

* Patients admitted to the following inpatient health care facilities; Acute or Intermediate Care, CTC, SNF, PIP, MHC, etc., shall have access to all non-medicated comfort products only.



CCHCS Reentry Programs (REPS) PROGRAM GUIDELINES

Appendix K

CCHCS Reentry Programs (REPS) Healthcare Appointment Request Form

This form is for routine visits and/or procedures and is not required for emergency care.

Date	FCRP/MCRP Location		
Patient Name	Patient Signature	CDCR#	DOB
Appointment Request			
Service Requested:		Follow-up/New Symptom:	
<input type="checkbox"/> Medical	<input type="checkbox"/> Optometry	<input type="checkbox"/> Follow-up	
<input type="checkbox"/> Dental	<input type="checkbox"/> MAT	<input type="checkbox"/> New Symptom	
<input type="checkbox"/> Mental Health*			
Reason for Request:			

List of Medications:			
_____	_____	_____	
_____	_____	_____	
Received By			
Received By Name & Title (Print)	Signature	Date	
Clinician Review			
COMMENTS:			

CCHCS Clinician's Signature		Date	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
REPS Program Staff			

Scan and email this form to the Program Director, CCIII, and to the applicable email address listed in the *Healthcare Appointment Request Form Procedure*.

*Mental Health/BHR Program requests do not require approval, only notification.



January 2026

