Nursing Facility Transition or Diversion (NFTD) to Assisted Living Facility & Community Transition Services (CTS) to a Home
Fax to 1-213-985-1835

L.A. Care HEALTH PLAN

L.A. Care Health Plan offers long-term care alternative services for Members who meet nursing facility level of care and willing and able to transition from a Nursing Facility or to remain in the community.

☐ Initial services ☐ Continuation of services

External Source Lead *NPI Required

☐ Hospital* (Part of Discharge Plan) ☐ Skilled Nursing Facility* (Part of Discharge Plan) ☐ ECM Provider*
☐ Community Based Adult Services* ☐ Community Based Organization* ☐ MLTSS Vendor*
☐ Community Supports Provider* ☐ Member's PPG/MSO/PCP/Specialist ☐ Other

Please Specify:

If you Marked a box with an (*) asterisk above, you must enter NPI below. If you do not have an NPI fill out rest of the information.

NPI*: Fax Number:

Contact Name:

Contact Phone Number: Email Address:

☐ Checking this box attests that Program Eligibility for Extra benefits & Services have been discussed and have received "Member Consent" to collect necessary clinical & supportive documentation from qualified clinical practitioner with direct knowledge and treatment responsibility.

Internal L.A. Care Source Lead

☐ Behavioral Health ☐ Care Management* ☐ Customer Solution Center
☐ Community Supports ☐ Social Services ☐ Utilization Management
☐ Managed Long Term Services & Supports (MLTSS)

*Is this referral a result of Care Management Interdisciplinary Care Team (ICT) meeting? ☐ Yes ☐ No

If Yes, Date of ICT: M M / D D / Y Y

Member information

Member Number Member DOB (M M / D D / Y Y Y Y) Member Phone

First Name Last Name

Member's Address & Language preference are on file with L.A. Care and will be used to process this request. Any updates must be completed by contacting Customer Service 24 hours a day-7days a week

Caregiver/Authorized Rep. Contact information & Official Designation Title

First Name Last Name
Phone Number Title/Relationship

Requesting Provider or Member's PCP Information

Requesting Provider or Member's PCP NPI Phone Fax
Requesting Provider or Member's PCP Name
Requesting Provider or Member's PCP Address
Requesting Provider or Member's PCP City Zip LAC Provider ID

An In-Network Provider NPI & Provider ID are required to complete this form. Find these at: https://www.lacare.org/find-doctor-or-hospital

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Request priority (If left blank will be processed as Routine)

- ☐ Routine
- ☐ Expedited
  - ☐ Member discharging from Hospital/LTACH/SNF
  - ☐ Member faces serious or imminent threat to his/her health

Requested Service and Program Eligibility (Please check every box applicable)

For Members in a Nursing Facility

☐ **Nursing Facility Transition to Assisted Living Facility**

Member must:

- ☐ be currently residing in a Nursing Facility for 60+ days; **AND**
- ☐ be willing to live in an assisted living setting as an alternative to a Nursing Facility; **AND**
- ☐ be able to reside safely in an assisted living facility with appropriate and cost-effective supports

☐ **Community Transition Services to a Home**

Member must:

- ☐ be currently living in a Nursing Facility or Medical Respite setting for 60+ days; **AND**
- ☐ be currently receiving medically necessary nursing facility Level of Care (LOC) services; **AND**
- ☐ be interested in moving back to the community choosing to transition to a home setting in lieu of remaining in the nursing facility; **AND**
- ☐ be able to reside safely in the community with appropriate and cost-effective supports; **AND**
- ☐ be willing and able to pay for their own living expenses

For Members in the Community

☐ **Nursing Facility Diversion to Assisted Living Facility**

Member must:

- ☐ be interested in remaining in the community; **AND**
- ☐ be willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; **AND**
- ☐ be currently receiving or meets minimum criteria for medically necessary nursing facility Level of Care (LOC); **AND**
- ☐ chooses to remain in the community to receive medically necessary nursing facility (LOC) services at an Assisted Living Facility

Continuity of Care

Has Member had any previous Community Transition Services approved from other health plan?

- ☐ Yes — Please indicate the Health Plan Name: | | | | | | | | | | | | |
- ☐ No

Clinical Information

Diagnosis:

Primary ICD-10 Code 1	Secondary ICD-10 Code	Other ICD-10 Code 1	Other ICD-10 Code 1

Does Member have any of the following conditions? (check all that apply):

- ☐ Diabetes
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Chronic lung disorders
- ☐ Cancer
- ☐ Human immunodeficiency virus (HIV)
- ☐ Chronic or disabling behavioral health disorders
- ☐ Functional limitations Describe:

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L.A. Care HEALTH PLAN

Currently enrolled in L.A. Care Programs? (Check all that apply)

- ☐ Care Management Program — Case Manager Name:
- ☐ In Home Supportive Services (IHSS) ☐ Palliative Care ☐ Community Based Adult Services (CBAS)
- ☐ Multipurpose Senior Services Program (MSSP) ☐ Home and Community Based Alternatives (HCBA)
- ☐ Enhanced Care Management (ECM)
- ☐ Community Supports — Program Name:
- ☐ Other

Has member recently accessed the Emergency Department, Hospital or a Nursing Home within the last 6 months?

☐ Yes Date of Discharge M M / D D / Y Y ☐ No

Home Health services for skilled needs:

☐ PT ☐ OT ☐ ST ☐ Nursing ☐ Other

Member's Current General Condition (check all that apply):

Ambulation:

- ☐ Steady Gait
- ☐ Ambulatory with assistance
- ☐ Confined to wheelchair
- ☐ Ambulatory with assistive device (cane, walker)
- ☐ Incontinent
- ☐ History of falls
- ☐ Most recent fall date: M M / D D / Y Y
- ☐ Medications with side effect that increases the risks for falls
- ☐ Supervision/Assistance with 2 or more ADL's/IADL's (i.e. hygiene, med management, etc.)
- ☐ Other (Specify)

Current Social Supports (check all that apply):

- ☐ Currently resides in Nursing Facility — Name of Facility:
- ☐ Previously Homeless
- ☐ No Social Supports
- ☐ Lives alone, but has outside support
- ☐ Alone for significant parts of the day and requires extensive routine supervision
- ☐ Lives with Partner/Spouse/Family — If yes, able/available to provide support ☐ Yes ☐ No
- ☐ Has unpaid Caregiver assistance — If yes, how many hours per day? Hours/Day
- ☐ Other (specify)

Summary of member issue(s), need(s), and concern(s):

Clinical and Supporting Attachments

☐ **Applicable supporting medical documentation must include:**

- If this is a part of a discharge plan from a SNF, please attach H&P and Discharge Plan.
- Latest MD visit notes with diagnoses, conditions, medications, treatment orders.
- PT/OT/ST/DME evaluation documenting safety needs.
- Medication reconciliation list
- Any assessments documenting member's physical needs and identification of need for home modification services or equipment.
- Current IDT Notes
- If recently discharged from Hospital, please attach Discharge Summary.