



L.A. Care Health Plan’s Day Habilitation Program provides services to eligible members. Day Habilitation is a part of L.A. Care’s health services called Community Supports. To submit an authorization request, all required fields in this form must be completely filled out and submitted via Secure Fax (**213.536.0630**). If the Secure Fax is not accessible, please submit via Secure Email **DayHab-Referrals@lacare.org**.

This form is only for L.A. Care Medi-Cal and Dual Eligible Special Needs Plan members. This form is NOT for members from Anthem or Blue Shield Promise. Please refer to the L.A. Care Day Habilitation Eligibility Criteria for more information.

Required responses are identified with an asterisk.*

Type of Request:*

- Initial (must also complete Section F) Reauthorization (must also complete Section G)

Eligibility Criteria (Section A)*

- Member is experiencing homelessness; OR
- Member exited homelessness and entered housing in the last 24 months; OR
- Member is at-risk of homelessness

If box is NOT checked, STOP. Member does not meet eligibility criteria. If box is checked, move on to next section.

For more information on the eligibility criteria, please visit our website. [Click Here](#)

Member Information (Section B)

First Name:* _____ Last Name:* _____
Medi-Cal Client ID# (CIN):* _____ L.A. Care Medi-Cal:* Dual Eligible Special Needs Plans*
Gender:* Female Male Transgender Female Transgender Male Non-Binary Other _____
Preferred Language:* _____ Date of Birth:* _____
Primary Phone Number:* () _____ HMIS I.D. if available: _____
Authorized Representative Name: _____ Phone Number: () _____

Referral Source Information (Section C)

Date of Referral:* _____
Internal referring department (select one):* BH CM CRC ECM MLTSS SS Other: _____
External referral by (select one):* ECM provider Homeless Provider CSProvider Other: _____
Referring Individual Name:* _____
Referring Organization Name:* _____
Referring Organization Address:* _____
Referring Secure Fax Number:*() _____
Referrer Phone Number:*() _____
Referrer Secure Email Address:* _____



For Referring Individual to Complete (Section D)*

Check here if you have obtained "Member Consent" to enroll (Opt-In) into L.A. CARE HEALTH PLAN's Day Habilitation Program and you will be able to present documentation substantiating this claim with dates, times, signature, voice capture, and/or phone records which will be required upon any prospective audit.

Member Housing Status Information (Section E)

Current living location:* _____

If you selected Other, please specify: _____

Current SPA location:* _____

Mailing address or location: _____

Services Being Requested (Section F) [select all that apply]:*

- Housing Support
- Life Skills/Independent Living
- Financial Management/Employment

Reauthorization (Section G)* [complete if member is currently enrolled in Day Habilitation]

Provider is requesting additional 6 months of Day Habilitation services on behalf of member:

Provider has assessed member's need for ongoing day habilitation services and has updated member's assessment in the last 60 days Yes No

Last successful member contact (must be within last 60 days):* ____/____/____

Services being requested [Select all that apply]:

- Housing Support
- Life Skills/Independent Living
- Financial Management/Employment

Additional Information:

Please share any additional information on the member's Day Habilitation service needs:

By submitting this authorization request form, I attest that the information above is true and accurate to the best of my knowledge.