L.A. Care HEALTH PLAN

Managed Long Term Services and Supports (MLTSS) Referral Form

Phone: 855.427.1223 • Fax: 213.438.4866
Email: mltss@lacare.org *(send via secured email only)*

Referral Source: _____ **Date of Referral:** ____-____-_____

Internal to L.A. Care:

☐ Case Management ☐ Utilization Management ☐ Social Worker ☐ Behavioral Hhealth
☐ Customer Solutions Center ☐ Other *(specify)*: _____

External:

☐ Member/Family/Caregiver ☐ Provider ☐ Hospital ☐ SNF ☐ Pharmacy ☐ PPG/IPA: _____
☐ Community Based Organization ☐ CBAS ☐ MSSP ☐ Vendor ☐ Other *(specify)*: _____

Referred by: _____ **Phone and extension:** _____

Member is currently: ☐ In a nursing facility under skilled care ☐ Acute hospital ☐ N/A

(Referral MUST be completely filled out or referral will be declined and returned to referral source.)
If member is inpatient, please complete Utilization Management Authorization Request Form which can be found on our website: http://www.lacare.org/sites/default/files/la1988_authorization_request_form_0718.pd

SECTION I: Member information

Member Name: _____ Gender: ☐ M ☐ F D.O.B: ____-____-_____ Age:_____

CIN: _____ Current Address: _____ Language: _____

LOB: ☐ MCLA ☐ CMC City: _____ Zip: _____ Phone: _____

Authorized Representative: _____ Consent to speak to AR: ☐ Yes ☐ No Phone: _____

SECTION II: Clinical information

Diagnosis: _____

Currently enrolled in L.A. Care Case Management Program?

☐ **Yes** ☐ **No** **Case Manager:** _____ **Ext.** _____

Has member recently been admitted to:

☐ **Emergency Room** ☐ **Hospital** ☐ **SNF** ☐ **Discharge Date:** ____-____-_____

Member's general condition (check all that apply):

☐ Ambulatory ☐ Ambulatory with assistance ☐ Maximum assist with all ADL's/IADL's ☐ Confined to bed
☐ Confined to wheelchair ☐ Incontinent ☐ Other *(specify)*: _____

Current Social Supports (check all that apply):

☐ None ☐ Lives alone, but has outside support ☐ Lives with Partner/Spouse/Family
☐ Resides in group home/B&C/Assisted Living/Senior Living/Etc. ☐ Has unpaid caregiver assistance
☐ Receives IHSS ☐ Other *(specify)*: _____

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

SECTION III: Requested MLTSS Service(s)

☐ **Long Term Care (LTC) Nursing Facility**
**Please check all that apply AND complete summary section on page 1*

Reason for LTC Diversion Referral:

- ☐ Be at home, at risk in community
- ☐ Needs 24 hr. care/assistance with ADLs
- ☐ Other *(specify)*: _____

☐ **In Home Supportive Services IHSS**
**Please check all that apply AND complete summary section on page 1*

Member must:

- ☐ Be age 65 years of age or older, or blind or disabled
- ☐ Meet Medi-Cal eligibility criteria
- ☐ Have a disability that will last 12 months or longer
- ☐ Not live in a Board and Care, SNF or Assisted Living Facility

AND

- ☐ Unable to perform activities of daily living independently at risk of institutionalization

Reason for IHSS Referral:

- ☐ Initial application
- ☐ Increase in hours
- ☐ Issues regarding time sheets
- ☐ Change in Provider/Caregiver
- ☐ Re-evaluation/Change in health status
- ☐ Denied services/Needs assistance with G&A process
- ☐ Other *(specify)*: _____

_____

_____

☐ **Multipurpose Senior Services Program (MSSP)**
**Please check all that apply AND complete summary section on page 1*

Member must:

- ☐ Be 65 years of age or older
- ☐ Be currently eligible for Medi-Cal
- ☐ Be certified or certifiable for placement in a nursing facility

Reason for MSSP Referral:

- ☐ Initial application
- ☐ Other *(specify)*: _____

☐ **Care Plan Options (CPO)**
**Please check all that apply AND complete summary section on page 1*

Have community resources been accessed already?

☐ Yes ☐ No

Member must:

- ☐ Be enrolled in Cal MediConnect (CMC)

☐ **Community Based Adult Services (CBAS)**
**Please check all that apply AND complete summary section on page 1*

Member must:

- ☐ Be 18 years or older and have Medi-Cal with L.A. Care

AND one or more of the following:

- ☐ At risk for nursing facility placement
- ☐ An organic, acquired or traumatic brain injury, and or chronic mental disorder AND needs assistance with activities of daily living
- ☐ Mild to severe cognitive disorder
- ☐ Mild cognitive disorder such as dementia AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication, management, or hygiene
- ☐ Developmental Disability

Reason for CBAS Referral:

- ☐ Initial request
- ☐ Increase in days
- ☐ Request to change CBAS center
- ☐ Other *(specify)*: _____

_____

_____

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