CBAS Face to Face Assessment Request (CEDT)

L.A. Care HEALTH PLAN
For All of L.A.

Note: This form is to be used for NEW CBAS referrals only.

To: **Refer to L.A. Care CEDT vendor zip code assignment list**

	CEDT Vendor	Fax Number
☐	AltaMed	323.307.0296
☐	Huntington Hospital Senior Care Network	626.397.2982
☐	Jewish Family Services	323.935.5161
☐	Partners in Care Foundation	818.979.0473

☐ Routine ☐ Expedited (member in hospital or SNF whose discharge plan includes CBAS)

CIN: _____ Member: _____
(Last name, First name)

DOB: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ City: _____ Zip: _____

Phone: _____ Preferred Language: _____

Authorized Representative (AR): Yes ☐ No ☐ N/A ☐

If yes,

AR Name: _____ Relationship: _____

AR Phone: _____

Referring CBAS Center Name: _____

Address: _____ City: _____ Zip: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

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Required:

☐ Verified Member has not received CBAS services in the past year
(form not to be used for transfer and reinstatement requests)

☐ Verified Medi-Cal eligible with L.A. Care Health Plan

☐ Attached current History & Physical

☐ Attached MD Order for CBAS services

Referral submitted by: _____ Date: _____
(Print Name)