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 Health
☐ 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.

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 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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