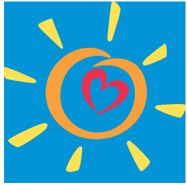

Community Based Adult Services (CBAS) Face-to-Face Assessment Request

CBAS Eligibility Determination Tool (CEDT)

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

To: Refer to L.A. Care Health Plan's CEDT vendor zip code assignment list

CEDT Vendor	Fax Number
☐ Jewish Family Services	323.935.5161
☐ Partners in Care Foundation	818.979.0473
☐ L.A. Care Health Plan	213.438.4866

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

Medi-Cal Client Identification Number (CIN): ______________________

Member: ______________________
(Last name, First name)

Date of Birth: ____________ Gender: ☐ Male ☐ Female ☐ Other

Address: ______________________ City: ____________ Zip: ________

Phone: ______________________ Preferred Language: ______________________

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

If yes,
AR Name: ______________________ Relationship: ____________
(Last name, First name)

AR Phone: ______________________ Referral Source: ______________________

Address: ______________________ City: ____________ Zip: ________

Contact Person: ______________________ Title: ______________________

Phone: ______________________ Fax: ______________________

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

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

Prior to enrollment, the CBAS Center must obtain:

Physician's Order

- May be part of the H & P, if not a separate order is needed
- Prescription is acceptable

Physician's History and Physical (within the last 90 days)

- H & P from the participant's primary care provider (PCP)
- If the center is unable to obtain from the PCP, center may submit urgent care, other physician specialists the participant sees, hospital records or the center's staff physician documents.

Medical documentation must include:

- Diagnoses,
- Conditions,
- Medications,
- Any medications to which the participant is allergic, and
- Dietary restrictions.

Referral submitted by: ______________________________ Date: ____________________

(Last name, First name)