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 ☐ TOC ☐ Social Worker ☐ Disease Management
☐ Member Services ☐ Other *(specify)*: ______________________________

External:

☐ Member/Family/Caregiver ☐ Provider ☐ Hospital ☐ SNF ☐ Pharmacy ☐ PPG/IPA: __________
☐ 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 need is for LTC Nursing Facility, complete the Long-Term Care Authorization Request Form**

SECTION I: Member information

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

CIN: ______________ Current Address: ______________________ Language: ______________

LOB: ______________ City: ______________________ Zip: __________ Phone: ______________

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

SECTION II: Clinical information

Diagnosis: ______________________________

Currently enrolled in internal CM or TOC 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): ______________________________

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SECTION III: Requested MLTSS Service(s)

☐ **LTC Nursing Facility Diversion**

**Please check all that apply AND complete summary section on page 1*

Reason for LTC Diversion Referral:

- ☐ To reduce the risk of or prevent premature institutionalization
- ☐ Member is receiving short term skilled care in skilled nursing facility (SNF)
- ☐ Member qualifies for nursing home placement, but wants to stay home with additional services and supports
- ☐ Other *(specify)*: ____________________

☐ **IHSS**

**Please check all that apply AND complete summary section on page 1*

Member must:

- ☐ Be aged, blind or disabled
- ☐ Meet Medi-Cal eligibility criteria
- ☐ Have a disability that will last 12 months or longer
- ☐ Be a U.S. citizen or have a qualified alien immigration status
- ☐ Not live in a Board and Care, SNF or Assisted Living Facility

AND

- ☐ Unable to perform one or more ADL's independently at risk of placement in out-of-home care without services to assist with the ADL

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)*: ____________________

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☐ **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
- ☐ Change in service
- ☐ Denied services
- ☐ 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)
- ☐ Have a completed Health Risk Assessment (HRA)

☐ **CBAS**

**Please check all that apply AND complete summary section on page 1*

Member must:

- ☐ Be 18 years or older / Have Medi-Cal/Requires assistance with 2 or more ADL's/IADL's

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
- ☐ Moderate 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

Reason for CBAS Referral:

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

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☐ **PACE**

**Please check all that apply AND complete summary section on page 1*

Member must:

- ☐ Be 55 years or older
- ☐ Be able to live independently in the community at time of enrollment
- ☐ Qualify for nursing home placement

SECTION III: Requested MLTSS Service(s) *Continued*

☐ **Home and Community-Based Services (HCBS)**

**Please check all that apply AND complete summary on page 1*

- ☐ Housing
- ☐ Transportation
- ☐ Waiver Program
- ☐ Disabled and Senior Services
- ☐ Other *(specify)*: ______________________________

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☐ **Complex Social Services (CSS)**

**Please check all that apply AND complete summary on page 1*

Member Must:

- ☐ Be enrolled in Cal MediConnect (CMC)
- ☐ Have a completed Health Risk Assessment (HRA)

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