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

☐ 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.*

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

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: _____
(Last name, First name)

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