

## L.A. Care's Recuperative Care Prior Authorization Request

Please fax completed document to 213.536.0634

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment but are otherwise ill enough to be in a hospital. This form is intended to be used only for L.A. Care Members and is not for members enrolled with Anthem, Blue Shield and Kaiser

Type of Request: 🗌 Initial	Bed transfer (For Recuperative Care Providers Only)	
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Reason for Recuperative Care Referral:

Criteria the member meets. Check all that apply:

🗌 Homeless 🛛 🗌 At-risk of homelessness 🔹 🗍 At-risk of hosp	pitalization
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Need to heal from an illness or injury (including behavioral health conditions) and have a condition which would be exacerbated by an unstable living environment.

If box is **NOT** checked, **STOP.** Member **does** not meet eligibility criteria. If box is checked, move on to next section.

Mem	ber's	Current	Location*
MCIII		Current	Location

Street Shelter Clinic Home Hospital Emergency Department					
□ Interim Housing □ LTC □ Recuperative Care □ Other:					
Name of current location:					
Address of current location:					
If member is in an institution, please provide the following:					
Date of admission:// Diagnoses:					
Referral Source Information					
Date of Referral:*					
L.A. Care Internal referring department* <i>(select one)</i> : BH CM MLTSS SS Other:					
External referral by* ( <i>select one</i> ): Clinic ECM Hospital PCP PPG Recup					
Other:					
Referring Individual Name:*					
Referring Organization Name:*					
Referrer Phone Number: *					
Referre Fax Number:*					
Referrer Email Address:*					



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#### **Member Information**

Member's Medi-Cal Number:*		Member Date of birth:*//		
Member's	Phone Number:			
Member's	First:	Member Last Name:*		
Check he be able t	nere if you have obtained "member consent" to enroll (Opt-in) to present documentation substantiating this member's cons	Transgender Male Non-Binary Other into L.A. Care Health Plan's Recuperative Care Program and you will sent upon any prospective future audit.		
	Information			
Height:	Weight: All	ergies:		
General Me	edical Diagnoses/Problems:			
Mental Hea	ealth/Substance Use Diagnoses/Problems:			
1 2 3	Can member Self-Represent? Yes No Does the member have impaired cognition: N Is member Independent w/ADLs? Yes No If NO, please explain:			
4	What is the member's ambulation status? feet			
6	Can the member self-administer all medication?  Yes No If NO, please explain:			
7	Does the member have control of Bladder, Bowel Does the member require any of the following? (0	Check all that apply):		
9	Colostomy Care Catheter Care Wound Care Does the member require Oxygen? Yes No			
	If YES, liters required:			
10	Will the member require any of the following? <i>(Check all that apply)</i> :			
11	Can member perform wound care independently?			
12	Does the member require IV Antibiotics: 🗌 Yes			

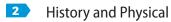


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Substance Use (Check all that apply):          Alcohol         Opioid Use (Heroine, Fentanyl)         Stimulant Use (Cocaine, Methamphetamin         Other	nes)
<b>Recuperative Care Placement</b> (to be completed if an accepting recuperative care	
Name of accepting Recuperative Care Program:	
Name of staff accepting referral:	_ Title :
Phone Number:	
Email Address:	

# For assistance with recuperative care placement, please attach the following documents.

1 Face Sheet



- 3 Medication List
- 4 Wound Care Notes
- 5 Psych Notes (if applicable)

#### For referrals coming out of the Emergency Room Department Please attach the following documents.

- Face Sheet
- 2 Lab/Tests performed in ED
- 3 ED Chart Notes
- Supporting documents such as Social Work Notes, paramedic notes, etc.

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