

Environmental Accessibility Adaptations (EAA)



Non-Provider Lead for Program Participation

Fax to 1-213-985-1835

L.A. Care Health Plan offers Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) for eligible members to ensure their health, welfare, and safety at home. MD order required.

External or Internal Lead Information for participation in program													
External Source Lead *NPI Required													
Hospital* (Part of Discharge Plan) Skilled Nursing Facility* (Part of Discharge Plan) ECM Provider*	ECM Provider*												
Community Based Adult Services* Community Based Organization* MLTSS Vendor*	MLTSS Vendor*												
Community Supports Provider* Member's PPG/MSO Other	Other												
Please Specify:													
If you Marked a box with an (*) asterisk above you must enter NPI below. If you do not have an NPI fill out rest of the information.													
NPI*: Fax Number:													
Contact Name:													
Contact Phone Number: Email Address:													
Checking this box attests that Program Eligibility for Extra benefits & Services have been discussed and have received "Member Consent" to collect necessary of	linical &												
supportive documentation from qualified clinical practitioner with direct knowledge and treatment responsibility. Internal L.A.Care Source Lead													
Behavioral Health Care Management* Customer Solution Center													
Safety Net Initiatives/CalAIM Social Services Utilization Management													
Managed Long Term Services & Supports(MLTSS)													
*Is this referral a result of Care Management Interdisciplinary Care Team (ICT) meeting? Yes No													
If Yes, Date of ICT: M M / D D / Y Y													
in test, but e on ter.													
Member information													
Member DOB Member Phone	Member Phone												
Member's Address & Language preference are on file with L.A.Care and will be used to process this request. Any updates must be completed by contacting Custor	ner Service												
24 hours a day-7days a week	ici service												
Caregiver Contact information & Official Designation Title													
First Name Last Name Last Name													
Discuss Name is an analysis of the Control of the C													
Phone Number Title/Relationship													
Requesting Provider or Member's PCP Information													
Requesting Provider or Member's PCP Information Requesting Provider or Member's PCP NPI Phone Fax													
Requesting Provider or Member's PCP Information													
Requesting Provider or Member's PCP Information Requesting Provider or Member's PCP NPI Phone Fax Requesting Provider or Member's PCP Name Requesting Provider or Member's PCP Name													
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If yes, please re-direct this request to PCP or treating doctor

Eligibility Criteria (Please check every box applicable)

Is requested service a DME Medi-Cal benefit?

Active Enrollment in L.A. Care's Medi-Cal HMO Plan; AND

Requested Environmental Accessibility & Adaption (EAA) Services

Clinical Documentation from Primary Care Physician (PCP) or Specialist which supports Medical necessity required for an EAA Service Authorization Request (SAR); **AND**

If for PERS, Member lacks caregiver support or supervision; OR

If for PERS, Home alone or unattended for significant periods of time at home;

Yes

If you answered yes to each of the items above and you are able to include clinical documentation at this time, please complete this entire Service Authorization Request (SAR) for EAA services and send via secure fax to the Managed Long Term Services and Supports (MLTSS) department.

Continuity of Care													
Have you had any previous home modifications or PERS approved from other health plans?													
Yes Please indicate the Health Plan name:													
No													
Requested Home Modifications EAA Services require an MD order and supporting documentation relating to Medical Necessity and how EAA will benefit	the me	mber.											
Custom made ramps to assist Member in accessing the home													
Custom made grab bars													
Doorway widening (Internal or External doors)													
Mechanical Stair lifts													
Safeway Step													
Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)													
Installation of specialized electric or plumbing systems that are necessary to accommodate the Member's medical equipment/supplies													
Other Other													
Other Other													
Other Other													
PERS (Personal Emergency Response System)													
Homebound Yes No													
Clinical Information													
Known Cognitive Impairment: Yes No													
Does the member have cognitive issues where they would not use the PERS appropriately? Yes No													
Recent change in condition: Yes No													
	Functional limitation Increased weakness												
Pain Shortness of breath Other													
Currently enrolled in L.A. Care Programs? (Check all that apply)													
Care Management Program Case Manager Name:													
In Home Supportive Services (IHSS) Palliative Care Community Based Adult Services (CBAS)													
Multipurpose Senior Services Program (MSSP) Home and Community Based Alternatives (HCBA)													
Enhanced Care Management (ECM)													
Community Supports Program Name:													
Other Other													
Has member recently accessed the Emergency Department, Hospital or a Nursing Home within the last 6 months?													
Yes Date of Discharge M M / D D / Y Y NO													
Home Health services for skilled needs:													
PT OT ST Nursing Other													



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Member's General Condition (check all that apply):																								
Ambulation:	Steady Ga	it	Ambulatory with assistance Co										ined	l to v	vhee	elch	nair							
	Ambulato	ry with	n assi	, wal	ker)								Incor	ntine	nt									
	History of f	alls					Mos	st re	cent fa	all dat	e:				M	M	/	D	D	/	Υ	Υ		
Medications with side effect that increases the risks for falls													-											
Supervision/Assistance with 2 or more ADL's/IADL's (i.e. hygiene, med management, etc.)																								
	Other(Spec	cify)																		L				
Current Social Supp	Current Social Supports (check all that apply):																							
None		Lives alone, but has outside support																						
Alone for significant parts of the day and requires extensive routine supervision																								
Lives with Partner/Spouse/Family								If v	es. ab	le/av	ailak	ole t	o pro	ovide	supr	ort		No						
	Has unpaid Caregiver assistance						If yes, able/available to provide s If yes, how many hours per day																	
Other (spec								<u>,</u>	, 55,	<u> </u>	1			1					1	T	1	Т		Τ
		1/ -	\		/ - \	_														\perp				
Summary of member issue(s), need(s), and concern(s):																								
Clinical and Suppor	ting Attachn	nents																						
Applicable supporting medical documentation should include:																								
 MD order 	must be atta	ched.																						
If this is a	part of a disc	harge	plan	from	an acu	te fac	ility c	or SN	NF, ple	ease a	attac	ch H	I&P a	nd D	C Pla	n.								
Latest MD	visit notes w	ith dia	agnos	ses, co	nditio	ns, me	edica	tion	s, tre	atmei	nt or	rder	s.											
PT/OT/DN	E evaluation	docur	ment	ing sa	fety ne	eds.																		
Any assess	ments docur	nentin	ng me	mber	's phys	sical n	eeds	and	d iden	tificat	ion	of n	need	for F	AA se	rvice	sore	eaui	ome	nt.				

If recently discharged from Hospital, Skilled Nursing or Long Term Care, Please attach DC summary.

To fill out an online copy of this form please go to www.lacare.org/provider.materials/BlockFaxForms