L.A. Care HEALTH PLAN®

Short Term Post Hospitalization Prior Authorization Request

Please fax completed document to **1.213.536.0634**

Short-Term Post-Hospitalization Housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery. This form is intended to be used for L.A. Care Members and is not for members enrolled with Anthem, and Blue Shield.

Has member previously utilized STPHH benefits? ☐ Yes ☐ No
(This is a once in a lifetime program, if the member has utilized this program, please do not submit a referral)

Is the member exiting an institution? ☐ Yes ☐ No
If checked "NO", member does not meet criteria for STPH.

If yes, please check type of institution: ☐ Inpatient hospital (acute, psychiatric, chemical dependency or recovery hospital) ☐ Residential Substance Use Disorder or recovery facility ☐ Residential mental health treatment facility ☐ Correctional facility ☐ Nursing facility ☐ Recuperative Care

☐ This program is available once in a member's lifetime. Please check this box to confirm that the member has been educated on this service and has agreed to use this once in a lifetime program. If the member has not agreed, please stop here and do not submit.

☐ Check here to attest to the best of your knowledge that the member meets the level of care criteria for Short Term Post Hospitalization (STPH) and does not require a higher level of care that cannot be met by STPH placement. For more information please **click here** for a list of STPH providers you may contact to learn more about their admission criteria.

Member Information

An asterisk (*) indicates a required field

Member's First name:* _____ Member's Last name:* _____

Member's Medi-Cal Number:* _____ Member Date of birth:* _____

Member's Phone Number:* _____ Member's Email Address:* _____

Member's Contact Preference: ☐ Phone ☐ Email

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other_____

Member Current Location

Name of the institution where the member is located: _____

Date of admission: _____

Diagnoses:

If member is in Recuperative Care Facility provide Date of Admission: _____

Was member at risk of homelessness or experiencing homelessness prior to institutionalization? ☐ Yes ☐ No

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Referral Source Information

Date of Referral:* _____

L.A. Care Internal referring department* (select one): ☐ BH ☐ CM ☐ MLTSS ☐ SS ☐ Other: _____

External referral by* (select one): ☐ Clinic ☐ ECM ☐ Hospital ☐ SNF ☐ PCP ☐ PPG ☐ Recup
☐ Other: _____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referrer Phone Number: * _____

Referrer Fax Number:* _____

Referrer Email Address:* _____

Alternative Contact Name:* _____

Alternative Contact Phone Number: _____

Health Information

Height: _____ Weight: _____ Allergies: _____

General Medical Diagnosis _____

Mental Health/Substance Use Diagnosis/Problems: _____

Can member Self-Represent? ☐ Yes ☐ No

Does the member have impaired cognition: ☐ Yes ☐ No

Is member Independent w/ADLs? ☐ Yes ☐ No

If NO, please explain: _____

Is the member dependent on any of the following DME?: ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Oxygen

Substance Use (Check all that apply):

☐ Alcohol

☐ Opioid Use (e.g. Heroine, Fentanyl)

☐ Stimulant Use (e.g. Cocaine, Methamphetamines)

☐ Other _____

Warm hand-off is strongly encouraged. We encourage the discharging institution to provide STPH providers with discharge information including home health arrangements, and HHSS/ECM information, if applicable.

For any questions, please email **ShortTermPostHops@lacare.org**