Community Supports Day Habilitation Service Authorization Request

L.A. Care Health Plan's Day Habilitation Program provides services to eligible members. Day Habilitation is a part of L.A. Care's health services called Community Supports. To submit an authorization request, all required fields in this form must be completely filled out and submitted via Secure Fax (**213.536.0630**). If the Secure Fax is not accessible, please submit via Secure Email **DayHab-Referrals@lacare.org**.

This form is only for L.A. Care Medi-Cal and Dual Eligible Special Needs Plan members. This form is NOT for members from Anthem or Blue Shield Promise. Please refer to the L.A. Care Day Habilitation Eligibility Criteria for more information.

Required responses are identified with an asterisk.*

Type of Request:*

☐ Initial (must also complete Section F) ☐ Reauthorization (must also complete Section G)

Eligibility Criteria (Section A)*

☐ Member is experiencing homelessness; OR

☐ Member exited homelessness and entered housing in the last 24 months; OR

☐ Member is at-risk of homelessness

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

For more information on the eligibility criteria, please visit our website. Click Here

Member Information (Section B)

First Name:* _____ Last Name:* _____

Medi-Cal Client ID# (CIN):* _____ ☐ L.A. Care Medi-Cal:* ☐ Dual Eligible Special Needs Plans*

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other _____

Preferred Language:* _____ Date of Birth:* _____

Primary Phone Number:* ( ) _____ HMIS I.D. if available: _____

Authorized Representative Name: _____ Phone Number: ( ) _____

Referral Source Information (Section C)

Date of Referral:* _____

Internal referring department (select one):* ☐ BH ☐ CM ☐ CRC ☐ ECM ☐ MLTSS ☐ SS ☐ Other: _____

External referral by (select one):* ☐ ECM provider ☐ Homeless Provider ☐ CSProvider ☐ Other: _____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referring Organization Address:* _____

Referring Secure Fax Number:*( ) _____

Referrer Phone Number:*( ) _____

Referrer Secure Email Address:* _____

L.A. Care HEALTH PLAN®

Community Supports Day Habilitation Service Authorization Request

For Referring Individual to Complete (Section D)*

☐ Check here if you have obtained "Member Consent" to enroll (Opt-In) into L.A. CARE HEALTH PLAN's Day Habilitation Program and you will be able to present documentation substantiating this claim with dates, times, signature, voice capture, and/or phone records which will be required upon any prospective audit.

Member Housing Status Information (Section E)

Current living location:* Select One

If you selected Other, please specify: _____

Current SPA location:* Select One

Mailing address or location: _____

Services Being Requested (Section F) [select all that apply]:*

☐ Housing Support

☐ Life Skills/Independent Living

☐ Financial Management/Employment

Reauthorization (Section G)* [complete if member is currently enrolled in Day Habilitation]

Provider is requesting additional 6 months of Day Habilitation services on behalf of member:

Provider has assessed member's need for ongoing day habilitation services and has updated member's assessment in the last 60 days ☐ Yes ☐ No

Last successful member contact (must be within last 60 days):*_____/_____/_____

Services being requested [Select all that apply]:

☐ Housing Support

☐ Life Skills/Independent Living

☐ Financial Management/Employment

Additional Information:

Please share any additional information on the member's Day Habilitation service needs:

By submitting this authorization request form, I attest that the information above is true and accurate to the best of my knowledge.