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Long Term Services & Supports

Phone: (855) 427-1223

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LONG TERM SERVICES & SUPPORTS (LTSS) REFERRAL

Date: _____ **Time:** _____

☐ **Routine** ☐ **Urgent** ☐ **Emergent ICT Request**

Referral Source:

INTERNAL:

☐ **Disease Management** ☐ **Utilization Management** ☐ **Social Worker** ☐ **Case Management** ☐ **Other**

EXTERNAL:

☐ **Member/Caregiver** ☐ **Hospital** ☐ **SNF** ☐ **Pharmacy** ☐ **Provider** ☐ **Other** _____

Referred By: _____ **Referral Contact Phone#:** _____

Member Name: _____ **PPG/IPA:** _____

Member CIN#: _____ **Member DOB:** _____

Member Phone: _____ **Language:** _____

Requested LTSS Services:	**Clinical Information**
☐ **IHSS** ☐ **MSSP** ☐ **CPO** ☐ **CBAS** ☐ **LTC (If Checked - Complete Long Term Care Authorization Rqst Form)** ☐ **Social Worker** ☐ **Home & Community Based Services**	**Diagnosis:** **Currently In Case Management:** ☐ **Yes** ☐ **No** **Case Manager:** **Extension#:** **Has the member recently been admitted to?** ☐ Emergency Room ☐ Hospital ☐ Skilled Nursing Facility **Discharge Date:** _____

Admitted From:	**Patient's General Condition:**	**Current Social Support:**
☐ Home ☐ Board & Care ☐ Acute Hospital ☐ Emergency Room ☐ SNF	☐ Confined To Bed ☐ Ambulatory ☐ Ambulatory with Assistance ☐ Wheelchair Confined ☐ Incontinent of Bowel and Bladder ☐ Maximum Assist with all ADLs ☐ Other Clinical Information:	☐ Lives alone ☐ Lives With Spouse/Family ☐ Has Caregiver Assistance ☐ Receives IHSS ☐ Other **Authorized Patient Representative:** Name: Phone#:

Reasons for Referral

- Member has an unmet social need and requires social services and support referrals
- Member needs in home assistance with Activities Daily Living (**ADL)** Instrumental Activities of Daily Living **(IADL)** (i.e., personal care or household chores)
- Member qualifies for nursing home placement, but wants to stay home with additional services and supports
- Member is residing in a Long Term Care (LTC) Facility and wants to go home
- Member/Member's authorized representative is requesting or needs caregiver support
- Member/Member's authorized representative needs assistance with Custodial Long Term Care
- Member is currently receiving LTSS services, however, needs additional support with In-Home Supportive Services (IHSS); Community Based Adult Services (CBAS); Multipurpose Senior Services Program (MSSP); LTC (Long Term Care)
- Member is requesting to file a grievance or appeal related to LTSS

FOR LTSS USE ONLY

***ALL CALLS MUST BE RETURNED WITHIN 24 BUSINESS HOURS**

Assigned To: _____

Call Returned Date: _____

Referral Type:

- ☐ **Long Term Care (LTC)**
- ☐ **Multipurpose Senior Services Program (MSSP)**
- ☐ **Community Based Adult Services (CBAS)**
- ☐ **In Home Supportive Services (IHSS)**
- ☐ **Care Plan Options (CPO)**
- ☐ **Other _____**
