



Long Term Care Referral Request Form

Resources other than LTC offered and explored prior to LTC referral? Yes No

Please check all that apply: In-Home Supportive Services (IHSS) Community Based Adult Services (CBAS)

Multipurpose Senior Services Program (MSSP)

Home and Community-Based Services (HCBS)

Long Term Care/ Custodial Referral Request: _____

Date of Referral: _____

SNF

Sub-Acute (Vent)

Sub-Acute (Non-Vent)

Initial

Re-Authorization

Retroactive Eligibility

Start of Service Date _____

Bed Hold/Leave of Absence Bed Hold Start Date: _____

SECTION I

PROVIDER: Authorization does not guarantee payment. L.A. Care Eligibility must be verified at the time the services are rendered.

Patient Name: _____ **Gender :** Male Female **D.O.B:** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **Zip** _____ **Phone #:** _____

CIN: _____ **Aid Code:** _____ **County Code:** _____

Primary Insurance: _____
Secondary Insurance: _____
Medicare Status:
 Benefits NOT Exhausted **Number of Medicare Days Available:** _____ **L.A. Care D-SNP**
 Benefits Exhausted **Date Medicare Benefits Exhausted:** _____ **D-SNP Other**

Facility Name: _____
Facility Address: _____
Facility Phone #: _____ **Facility Fax #:** _____
Facility Contact: _____

Physician Name: _____
Physician Address: _____
Physician Phone#: _____ **Physician Fax#:** _____

Diagnosis: _____

ICD-9 Code/s: _____

SECTION II

Admitted From:
 Home
 Board & Care
 Acute Hospital
 Emergency Room
 Another SNF
 Other _____

SECTION III

Date of LTC Placement Referral: _____
Community Options Available: Yes No
Type of Options: _____
Reason for LTC SNF Placement: _____

SECTION IV

Patient's General Condition:
 Bedridden
 Ambulatory Ambulatory with Assistance
 Wheelchair Confined
 Incontinent of B&B
 Maximum Assist with all ADLs
 Other _____

SECTION V

Referring Person Name: _____
Relationship or Title _____
Phone Number: _____
Additional Comments: _____

