Submit Print

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: _____
_____
_____