Caregiver Support Services
Service Authorization Request Form

L.A. Care Health Plan offers Caregiver Support for eligible Members for the following services:

- **Personal Care and Homemaker Services (PCHS)**
  - **Eligibility Requirements when Member:**
    - Has applied for IHSS pending decision
    - Approved to receive IHSS but awaiting decision related to change in condition
    - Seeking Additional IHSS Hours beyond DPSS Approved
    - Member was Denied / Ineligible for IHSS – Needed to avoid institutionalization
- **Respite Services for Caregivers**
  - Provided on a short-term basis due to the absence of the Primary Caregiver.
  - Services are nonmedical in nature and provided in the member's home.
  - Member requires caregiver relief to avoid institutional placement.

To request either service, complete this form in its entirety and submit with supporting documents via secure fax to the Managed Long Term Services and Supports (MLTSS) department.

Fax: 213.985.1835

Caregiver Support Services | Service Authorization Request Form

L.A. Care HEALTH PLAN

Date of Request: M M / D D / Y Y Y Y

Request Priority:
- ☐ Routine
- ☐ Expedited
  - *Member discharged from hospital/SNF
  - *Member faces serious or imminent threat to his/her health

Member First Name:

Member Last Name:

Authorized Representative Name:

Authorized Representative Phone #:

Relationship to Member:

Member ID# (CIN) 1 2 3 4 5 6 7 8 9

Member's Date of Birth M M / D D / Y Y Y Y

GENDER: ☐ Male ☐ Female ☐ Other

Member's Phone Number:

Member's Alternate Phone:

Best Time to Contact: ☐ Morning ☐ Afternoon

Preferred Language:

Referred by (Print Name):

Title:

Phone:

☐ **Change in Managed Care Plan (MCP), Previous MCP:**

Internal L.A. Care Service Request Source

- ☐ Behavioral Health
- ☐ Care Management*
- ☐ Customer Solutions Center
- ☐ Managed Long Term Services and Supports
- ☐ Safety Net Initiatives/ECM
- ☐ Social Services
- ☐ Utilization Management

*Is this referral a result of Care Management Interdisciplinary Care Team (ICT) meeting?

☐ Yes ☐ No **If yes, Date of ICT** M M / D D / Y Y Y Y

External Source by (select one):
- ☐ Hospital
- ☐ Skilled Nursing Facility
- ☐ Primary Care Physician/Participating Provider Group
- ☐ Enhanced Care Management Provider
- ☐ Community Based Adult Services Center
- ☐ MLTSS Vendor
- ☐ PCHS or Respite Provider

To be assigned by MLTSS if approved

Requesting or Prescribing Physician

Requesting Provider Name:

Phone Number:

NPI

Rendering / Service Provider

Service Provider Name:

Phone Number:

NPI

If you have obtained "Member Consent" to enroll (Opt-In) into L.A. CARE HEALTH PLAN's PCHS or Respite program if qualifications are met - please check here ☐

Caregiver Support Services | Service Authorization Request Form

L.A. Care HEALTH PLAN

Personal Care and Homemaker Services (PCHS)

☐ **Initial Service Request** *(Select applicable reason)*

☐ **Pending IHSS (Application) decision**

Application Date:

M	M	/	D	D	/	Y	Y	Y	Y

☐ **Pending Increase in IHSS Hours Due to Change in Condition (Interim Assessment REQUIRED)**

Request Date:

M	M	/	D	D	/	Y	Y	Y	Y

Current Approved IHSS Hours Monthly:

Is backup IHSS Caregiver available? ☐ Yes ☐ No

☐ **Member was Denied / Ineligible for IHSS**

Date Denied by DPSS:

M	M	/	D	D	/	Y	Y	Y	Y

Reason for Denial:

_____

Do any of these scenarios apply?

☐ Caregiver support needed above and beyond IHSS approved hours

☐ Member requires paramedical services. (e.g. Administering medication or giving injections, blood sugar checks, catheter care, insertion of suppositories, tube feeding, suctioning)

☐ **Continuation of services**

L.A. Care Auth. #

Number of Hours requesting per week:

Reason for continuation request:

☐ Change in Condition/Status

Describe Change:

_____

Respite Services

☐ **Initial Service Request**

Reason Primary Caregiver Unavailable *(check one)*

☐ Personal (caregiver need)

☐ Medical treatment (self)

Duration of Caregiver absence:

From date:

M	M	/	D	D	/	Y	Y	Y	Y

To date:

M	M	/	D	D	/	Y	Y	Y	Y

Number of Respite Hours Requested per day:

Is Member receiving IHSS ☐ **Yes** ☐ **No**

If yes, Current Approved IHSS Hours Monthly:

Is backup IHSS Caregiver available? ☐ **Yes** ☐ **No**

☐ **Continuation of services**

L.A. Care Auth. #

Number of Hours requesting per week:

Reason for continuation request: *(check all that apply)*

☐ Extended Caregiver Absence, *Reason:*

_____

Additional Duration of Caregiver absence:

From date:

To date:

M	M	/	D	D	/	Y	Y	Y	Y

M	M	/	D	D	/	Y	Y	Y	Y

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L.A. Care HEALTH PLAN®

Caregiver Information:

Caregiver Name (First Name Last Name)

Caregiver Phone #:

Relationship to Member

Clinical Information:

Primary Diganosis:

Known Cognitive Impairment: ☐ Yes ☐ No

If yes, ☐ Mild ☐ Moderate ☐ Severe

Behavioral Health Diagnosis:

Receiving Mental Health Services: ☐ Yes ☐ No

Recent change in condition: ☐ Yes ☐ No

If Yes, Type of Change in Condition:

- ☐ Cognitive decline
- ☐ Functional limitation
  - ☐ Increased weakness
  - ☐ Pain
  - ☐ Shortness of breath
  - ☐ Recent fall Date: M M / D D / Y Y Y Y
  - ☐ Other:

Currently enrolled in L.A. Care Programs? *(check all that apply)*

- ☐ Care Management Program, Case Manager Name:
- ☐ In Home Supportive Services (IHSS)
- ☐ Community Based Adult Services (CBAS)
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Palliative Care
- ☐ Enhanced Care Management (ECM)
- ☐ Community Supports Program:
- ☐ Home and Community Based Alternatives (HCBA)

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L.A. Care HEALTH PLAN®

Has member recently accessed any of the following within the last 6 months? *(check all that apply)*

☐ Emergency Room, *Date of Visit*:

M	M	/	D	D	/	Y	Y	Y	Y

☐ Hospital, *Discharge Date*:

M	M	/	D	D	/	Y	Y	Y	Y

☐ Skilled Nursing Facility, *Discharge Date*:

M	M	/	D	D	/	Y	Y	Y	Y

☐ Psychiatric Hospital, *Discharge Date*:

M	M	/	D	D	/	Y	Y	Y	Y

☐ PCP, *Last Visit Date*:

M	M	/	D	D	/	Y	Y	Y	Y

Home health services for skilled needs:

☐ PT ☐ OT ☐ ST ☐ Nursing ☐ Other: _____

# of visits per week: _____

Member's general condition *(check all that apply):*

Ambulation:

- ☐ Steady Gait
- ☐ Ambulatory with assistance
- ☐ Ambulatory with assistive device *(cane, walker)*
- ☐ Confined to wheelchair
- ☐ Supervision/Assistance with 2 or more ADL's/IADL's *(i.e. hygiene, med management, etc.)*
- ☐ Incontinent
- ☐ Other (specify) _____

_____

Current Social Supports *(check all that apply):*

- ☐ None
- ☐ Lives alone, but has outside support
- ☐ Lives with Partner/Spouse/Family
  If yes, able/available to provide support ☐ Yes ☐ No
- ☐ Has unpaid Caregiver assistance ☐ Yes ☐ No
  If yes, how many hours per day? _____
- ☐ Other (specify) _____

_____

Summary of member issue(s), need(s), and concern(s):

Clinical and Supporting Attachments

Supporting medical documentation should include:

- Latest MD visit notes with diagnoses, conditions, medications, treatment orders
- Any assessments documenting member's physical needs and identification of frailty
- PT/DME evaluation documenting safety needs
- Discharge summary if recently discharged from hospital or SNF
- Caregiver Status Report for proof of absence due to medical reason