# Community Based Adult Services (CBAS) Face-to-Face Assessment Request

## CBAS Eligibility Determination Tool (CEDT)

***Note:*** *This form is to be used for* ***NEW*** *CBAS referrals only*

**Fax to:** L.A. Care Health Plan **213.985.1835**

☐ Routine ☐ Expedited (member in hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS)

Medi-Cal Client Identification Number (CIN): _____

Member: _____

*(Last name, First name)*

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

Address: _____ City: _____ Zip: _____

Phone: _____ Preferred Language: _____

Authorized Representative (AR): ☐ Yes ☐ No ☐ N/A

*If yes,*

AR Name: _____ Relationship: _____

*(Last name, First name)*

AR Phone: _____ Referral Source: _____

Address: _____ City: _____ Zip: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

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L.A. Care HEALTH PLAN

## Clinical Information:

### Diagnosis:

Known cognitive impairment: ☐ Yes ☐ No If yes, ☐ mild ☐ moderate ☐ severe

Behavioral Health Diagnosis: _____ Receiving Mental Health Services: ☐ Yes ☐ No

Currently enrolled in L.A. Care Case Management Program? ☐ Yes ☐ No

If yes, Case Manager: _____ Ext. _____

### Has member recently accessed any of the following within the last 6 months?

Emergency Room _____ Date of Visit: _____

Hospital _____ Discharge Date: _____

SNF _____ Discharge Date: _____

Inpatient Psychiatric Hospital _____ Discharge Date: _____

PCP _____ Last Visit Date: _____

Specialist _____ Specialist Type: _____

Specialist _____ Specialist Type: _____

Home health services for skilled needs: ☐ PT ☐ OT ☐ Nursing Other: _____

Home Health # 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

☐ Resides in group home/B&C/Assisted Living/Senior Living/Etc. ☐ Has unpaid caregiver assistance

☐ Receives IHSS If yes, how many hours per month: _____

Other (specify): _____

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

_____

_____

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Required:

- ☐ Verified Member has not received CBAS services in the past year
  *(form not to be used for transfer and reinstatement requests)*
- ☐ Verified Medi-Cal eligible with L.A. Care Health Plan
- ☐ Attached current History & Physical
- ☐ Attached MD Order for CBAS services

## Prior to enrollment, the CBAS Center must obtain:

### Physician's Order

- May be part of the H & P, if not a separate order is needed
- Prescription is acceptable

### Physician's History and Physical (within the last 90 days)

- H & P from the participant's primary care provider (PCP)
- If the center is unable to obtain from the PCP, center may submit urgent care, other physician specialists the participant sees, hospital records or the center's staff physician documents.

### Medical documentation must include:

- Diagnoses,
- Conditions,
- Medications,
- Any medications to which the participant is allergic, and
- Dietary restrictions.

Referral submitted by: _____ Date: _____

*(Last name, First name)*