L.A. Care HEALTH PLAN®

L.A. Care's Recuperative Care Prior Authorization Request

Please fax completed document to 213.536.0634

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment but are otherwise ill enough to be in a hospital. **This form is intended to be used only for L.A. Care Members and is not for members enrolled with Anthem, Blue Shield and Kaiser**

Type of Request: ☐ Initial ☐ Bed transfer (For Recuperative Care Providers Only)

Reason for Recuperative Care Referral: _____

Criteria the member meets. Check all that apply:

☐ Homeless ☐ At-risk of homelessness ☐ At-risk of hospitalization

☐ Need to heal from an illness or injury (including behavioral health conditions) and have a condition which would be exacerbated by an unstable living environment.

If box is **NOT** checked, **STOP.** Member **does** not meet eligibility criteria. If box is checked, move on to next section.

Member's Current Location*

☐ Street ☐ Shelter ☐ Clinic ☐ Home ☐ Hospital ☐ Emergency Department
☐ Interim Housing ☐ LTC ☐ Recuperative Care ☐ Other: _____

Name of current location: _____

Address of current location: _____

If member is in an institution, please provide the following:

Date of admission: _____/_____/_____ Diagnoses: _____

Referral Source Information

Date of Referral:* _____

L.A. Care Internal referring department* *(select one)*: ☐ BH ☐ CM ☐ MLTSS ☐ SS ☐ Other:

External referral by* *(select one)*: ☐ Clinic ☐ ECM ☐ Hospital ☐ PCP ☐ PPG ☐ Recup

Other: _____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referrer Phone Number: * _____

Referre Fax Number:* _____

Referrer Email Address:* _____

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Member Information

Member's Medi-Cal Number:* _____ Member Date of birth:*____/____/_____

Member's Phone Number: _____

Member's First: _____ Member Last Name:* _____

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other_____

☐ **Check here if you have obtained "member consent" to enroll (Opt-in) into L.A. Care Health Plan's Recuperative Care Program and you will be able to present documentation substantiating this member's consent upon any prospective future audit.**

Health Information

Height: _____ Weight: _____ Allergies: _____

General Medical Diagnoses/Problems: _____

Mental Health/Substance Use Diagnoses/Problems: _____

1. Can member Self-Represent? ☐ Yes ☐ No
2. Does the member have impaired cognition: ☐ Yes ☐ No
3. Is member Independent w/ADLs? ☐ Yes ☐ No
   If NO, please explain:
   _____
4. What is the member's ambulation status? _____ feet
5. Is the member independent with transfer? ☐ Yes ☐ No
6. Can the member self-administer all medication? ☐ Yes ☐ No
   If NO, please explain:
   _____
7. Does the member have control of Bladder, Bowel, or Both? ☐ Bladder ☐ Bowel ☐ Both
8. Does the member require any of the following? *(Check all that apply)*:
   ☐ Colostomy Care ☐ Catheter Care ☐ Wound Care
9. Does the member require Oxygen? ☐ Yes ☐ No
   If YES, liters required: _____
10. Will the member require any of the following? *(Check all that apply)*:
    ☐ Wound ☐ Vac ☐ Bipap ☐ CiPap
11. Can member perform wound care independently? ☐ Yes ☐ No ☐ N/A
    If NO, authorization and home health arrangements required prior to discharge.
12. Does the member require IV Antibiotics: ☐ Yes ☐ No

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13 Is the member dependent on the following DME? ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair

14 Please identify any active communicable diseases: _____

15 Tuberculosis Test or Chest X-Ray Performed? ☐ Yes ☐ No

16 Is the member medically stable for transfer? ☐ Yes ☐ No

Substance Use *(Check all that apply)*:

☐ Alcohol

☐ Opioid Use (Heroine, Fentanyl) _____

☐ Stimulant Use (Cocaine, Methamphetamines)

☐ Other _____

Recuperative Care Placement

(to be completed if an accepting recuperative care has been identified)

Name of accepting Recuperative Care Program: _____

Name of staff accepting referral: _____ **Title :** _____

Phone Number: _____

Email Address: _____

Date you are requesting the authorization to begin: _____

(Please contact L.A. Care if the authorization start date changes)

For assistance with recuperative care placement, please attach the following documents.

1. Face Sheet
2. History and Physical
3. Medication List
4. Wound Care Notes
5. Psych Notes (if applicable)

For referrals coming out of the Emergency Room Department Please attach the following documents.

1. Face Sheet
2. Lab/Tests performed in ED
3. ED Chart Notes
4. Supporting documents such as Social Work Notes, paramedic notes, etc.