L.A. Care HEALTH PLAN®

Assisted Living Facility Transitions(ALFT) Community or Home Transition Services (CHTS)

Fax to 1.213.985.1835

L.A. Care Health Plan offers long-term care alternative services for Members who meet nursing facility level of care and willing and able to transition from a Nursing Facility or to remain in the community.

☐ Initial services ☐ Continuation of services

External Source Lead

☐ Hospital* (Part of Discharge Plan)
☐ Skilled Nursing Facility* (Part of Discharge Plan)
☐ ECM Provider*
☐ Community Based Adult Services*
☐ Community Based Organization*
☐ MLTSS Vendor*
☐ Community Supports Provider*
☐ Member's PPG/MSO/PCP/Specialist
☐ Other

Please Specify: _____

If you Marked a box with an (*) asterisk above, you must enter NPI below. If you do not have an NPI fill out rest of the information.

NPI*: _____ Fax Number: _____

Contact Name: _____

Contact Phone Number: _____ Email Address: _____

☐ Checking this box attests that Program Eligibility for Extra benefits & Services have been discussed and have received "Member Consent" to collect necessary clinical & supportive documentation from qualified clinical practitioner with direct knowledge and treatment responsibility.

Internal L.A. Care Source Lead

☐ Behavioral Health
☐ Care Management*
☐ Customer Solution Center
☐ Community Supports
☐ Social Services
☐ Utilization Management
☐ Managed Long Term Services & Supports (MLTSS)

*Is this referral a result of Care Management Interdisciplinary Care Team (ICT) meeting? ☐ Yes ☐ No

If Yes, Date of ICT: _____ / _____ / _____

Member Information

Member Number _____ Member DOB _____ Member Phone _____

First Name _____ Last Name _____

Member's Address & Language preference are on file with L.A. Care and will be used to process this request.
Any updates must be completed by contacting Customer Service 24 hours a day-7days a week

Caregiver/Authorized Rep. Contact information & Official Designation Title

First Name _____ Last Name _____

Phone Number _____ Title/Relationship _____

Referring Individual Information

Referring Individual Name _____

Referring Individual Phone Number _____ Referring Individual Fax _____

Referring Individual E-mail _____

Referring Individual Address _____

Referring Individual or Member's PCP City _____ Zip _____ LAC Provider ID _____

An In-Network Provider NPI & Provider ID are required to complete this form. Find these at: **lacare.org/find-doctor-or-hospital**

Requested Service and Program Eligibility (Please check every box applicable)

For Members in a Nursing Facility

☐ **Assisted Living Facility Transition**

Member must:

- ☐ be currently residing in a Nursing Facility for 60+ days; **AND**
- ☐ be willing to live in an assisted living setting as an alternative to a Nursing Facility; **AND**
- ☐ be able to reside safely in an assisted living facility with appropriate and cost-effective supports

☐ **Community or Home Transition Services**

Member must:

- ☐ be currently living in a Nursing Facility or Medical Respite setting for 60+ days; **AND**
- ☐ be currently receiving medically necessary nursing facility Level of Care (LOC) services; **AND**
- ☐ be interested in moving back to the community choosing to transition to a home setting in lieu of remaining in the nursing facility; **AND**
- ☐ be able to reside safely in the community with appropriate and cost-effective supports
- ☐ be willing and able to pay for their own living expenses

For Members in the Community

☐ **Assisted Living Facility Transition**

Member must:

- ☐ be interested in remaining in the community; **AND**
- ☐ be willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; **AND**
- ☐ be currently receiving or meets minimum criteria for medically necessary nursing facility Level of Care (LOC); **AND**
- ☐ chooses to remain in the community to receive medically necessary nursing facility (LOC) services at an Assisted Living Facility

SSI Status

☐ **Enrolled - Dollar amount:** _____ ☐ **Applied** ☐ **Not Yet Applied** ☐ **Ineligible**

Continuity of Care

Has Member had any previous Community Transition Services approved from other health plan?

☐ Yes Please indicate the Health Plan Name: _____

☐ No

Clinical Information

Diagnosis:

Primary ICD-10 Code 1 _____ Secondary ICD-10 Code _____

Other ICD-10 Code 1 _____ Other ICD-10 Code 1 _____

Does Member have any of the following conditions? (check all that apply):

- ☐ Diabetes
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Chronic lung disorders
- ☐ Cancer
- ☐ Human immunodeficiency virus (HIV)
- ☐ Chronic or disabling behavioral health disorders
- ☐ Functional limitations Describe: _____

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

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

Other _____

Has member recently accessed the Emergency Department, Hospital or a Nursing Home within the last 6 months?

☐ Yes Date of Discharge _____ / _____ / _____ ☐ No

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

Member's Current General Condition (check all that apply):

Ambulation:
☐ Steady Gait ☐ Ambulatory with assistance ☐ Confined to wheelchair
☐ Ambulatory with assistive device (cane, walker) ☐ Incontinent
☐ History of falls ☐ Most recent fall date: _____ / _____ / _____
☐ Medications with side effect that increases the risks for falls
☐ Supervision/Assistance with 2 or more ADL's/IADL's (i.e. hygiene, med management, etc.)
☐ Other (Specify): _____

Current Social Supports (check all that apply):

☐ Currently resides in Nursing Facility Name of Facility: _____
☐ Previously Homeless
☐ No Social Supports ☐ Lives alone, but has outside support
☐ Alone for significant parts of the day and requires extensive routine supervision
☐ Lives with Partner/Spouse/Family If yes, able/available to provide support ☐ Yes ☐ No
☐ Has unpaid Caregiver assistance If yes, how many hours per day? _____ Hours/Day
☐ Other (specify): _____

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

Clinical and Supporting Attachments

☐ **Applicable supporting medical documentation must include:**
- If this is a part of a discharge plan from a SNF, please attach H&P and Discharge Plan.
- Latest MD visit notes with diagnoses, conditions, medications, treatment orders.
- PT/OT/ST/DME evaluation documenting safety needs.
- Medication reconciliation list
- Any assessments documenting member's physical needs and identification of need for EAA services or equipment.
- Current IDT Notes
- If recently discharged from Hospital, please attach Discharge Summary.