L.A. Care HEALTH PLAN®

Caregiver Support Services
Authorization Request Form
Fax to 1.213.985.1835

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 short-term institution

Respite Services for Caregivers

- Provided on a short-term basis due to absence of the Primary Caregiver
- Services are nonmedical in nature and provided for 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: **1.213.985.1835**

☐ Expedited Request (Member discharged from hospital/SNF OR Member faces imminent threat to his/her health)

☐ Routine Request

External or Internal Lead Information for participation in program

☐ External Source (go to section A)
☐ Internal L.A. Care Source (go to section B)

Section A: External Source

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

_____

Section B: Internal L.A. Care Source

☐ Behavioral Health
☐ Care Management*
☐ Customer Solution Center
☐ Safety Net Initiatives/CalAIM
☐ 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: _____ / _____ / _____

☐ 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.

Referring Individual Information

Referring Individual Name _____

Referring Individual Phone Number _____ Referring Individual Fax _____

Referring Individual E-mail _____

Referring Individual Address _____

LAC Provider ID (if applicable) _____

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

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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 at **1.888.839.9909**

Caregiver Contact information & Official Designation Title

First Name_____ Last Name _____

Phone Number _____ Title/Relationship_____

Treating Provider or Member's PCP Information

Member's PCP/ Treating Provider NPI _____

Phone _____ Fax _____

Treating Provider or Member's PCP Name _____

Treating Provider or Member's PCP Address_____

Treating Provider or Member's PCP City _____ Zip _____ LAC Provider ID _____

☐ Check Here 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.

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

Personal Care and Homemaker Services (PCHS)

☐ Initial Service Request (Select applicable reason)

☐ Pending IHSS (Application) Decision Application Date _____ / _____ / _____

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

Request Date _____ / _____ / _____ Current Approved IHSS hours Monthly _____

Is Backup IHSS Caregiver available? ☐ Yes ☐ No

☐ Member was Denied/Ineligible for IHSS Date Denied by DPSS _____ / _____ / _____

Reason for Denial: _____

_____

_____

☐ Caregiver support needed above and beyond IHSS

☐ Continuation/Modification of Service Request

L.A. Care Auth. # _____

Reason for Modification Request ☐ Increase in Hours ☐ Decrease in Hours

☐ Change in Condition/Status (Please describe change below)

☐ Is member receiving Waiver Personal Care Services (WPCS) through HCBA waiver? ☐ Yes ☐ No

☐ Is member in the waiting list for Waiver Personal Care Services through waiver? ☐ Yes ☐ No

If yes, date of application? _____ / _____ / _____

Point of Contact (POC) information: Name/phone number/email, relationship to the member and time of call preference

Respite Services for Caregiver

☐ Initial Service Request

Reason Primary Caregiver Unavailable ☐ Personal (Caregiver need) ☐ Medical Treatment (Caregiver)

If the service request is due to medical treatment for caregiver, medical certification from licensed healthcare professional must be included

Duration of Caregiver Absence: From: _____ / _____ / _____ To: _____ / _____ / _____

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 ☐ Extended Caregiver Absence (Please provide reason Below)

Point of Contact (POC) information: Name/phone number/email, relationship to the member and time of call preference

☐ Additional Duration of Caregiver Absence: From: _____ / _____ / _____ To: _____ / _____ / _____

Clinical Information

Primary Diagnosis: _____

ICD-10 Code 1 _____ ICD-10 Code 2 _____ ICD-10 Code 3 _____ ICD-10 Code 4 _____

Known Cognitive Impairment ☐ Yes ☐ No If Yes: ☐ Mild ☐ Moderate ☐ Severe

Receiving Mental Health Services ☐ Yes ☐ No

Recent Change in Condition ☐ Yes ☐ No

If yes, Type of Change in Condition ☐ Cognitive Decline ☐ Functional Limitation

If Functional Limitation: ☐ Increased Weakness ☐ Shortness of Breath ☐ Pain

☐ Recent Fall, Date _____ / _____ / _____ ☐ Other (Please describe change below):

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

☐ Care Management, Case Manager: _____

☐ In-Home Supportive Services (IHSS) ☐ Community Based Adult Services (CBAS) ☐ Palliative Care

☐ Multipurpose Senior Services Program (MSSP) ☐ Enhanced Care Management (ECM)

☐ Community Supports Program: _____

Has the Member recently accessed any of the following within the last 6 months? (Check all that apply)

☐ Emergency Room, Date of visit _____ / _____ / _____

☐ Hospital, Discharge Date: _____ / _____ / _____

☐ Psychiatric Hospital, Discharge Date _____ / _____ / _____

☐ PCP, Last visit date: _____ / _____ / _____

Home Health Services for Skilled needs

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

# of visits per week: _____

Member's General condition (Check all that Apply)

Height _____ ft _____ in Weight _____ Pounds

Ambulation:

☐ Steady Gait ☐ Ambulatory with Assistance ☐ Confined to wheelchair

☐ Ambulatory with assistive device (Cane, Walker)

☐ Supervision/Assistance with 2 or more ADL's/IADL's (i.e. Hygiene, Medication management, etc.)

☐ Transfer Assistance ☐ Minimal ☐ Moderate ☐ Maximum

☐ Transfer Assistance Equipment ☐ Hoyer Lift ☐ Other _____

☐ 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 _____

☐ Other (Specify) _____

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

Clinical and Supporting Attachments

Supporting medical documentation should include:

- If this is a part of a discharge plan from an acute facility or SNF, please attach H&P, DC Plan and Case Manager's contact info.
- Latest MD visit notes with diagnoses, condition, medications, treatment orders
- Any assessments documenting member's physical needs and identification of frailty
- PT/OT/DME evaluation documenting safety needs
- Discharge summary if recently discharged form hospital or SNF
- Caregiver Status Report for proof of absence due to medical reason

Submitted by Signature _____ Date Signed _____ / _____ / _____