Caregiver Support Services
Authorization Request Form
Fax: 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 services, 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

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

Member information

Member Number	Member DOB	Member Phone
	MM/DD/YYYY	

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: https://www.lacare.org/find-doctor-or-hospital

Personal Care and Homemaker Services (PCHS)

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

☐ Pending IHSS (Application) Decision   Application Date MM/DD/YY

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

Request Date MM/DD/YY   Current Approved IHSS hours Monthly ___ . ___

Is Backup IHSS Caregiver available? ☐ Yes ☐ No

☐ Member was Denied/Ineligible for IHSS   Date Denied by DPSS MM/DD/YY

Reason for Denial:

☐ Caregiver support needed above and beyond IHSS

To fill out an online copy of this form please go to www.lacare.org/provider.materials/BlockFaxForms

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☐ **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)

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: MM/DD/YY To: MM/DD/YY

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)

Additional Duration of Caregiver Absence: From: MM/DD/YY To: MM/DD/YY

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: MM/DD/YY ☐ 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) ☐ Multipurpose Senior Services Program (MSSP)

☐ Palliative Care ☐ Enhanced Care Management (ECM)

☐ Community Supports Program:

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

☐	Emergency Room, Date of visit	MM/DD/YY
☐	Hospital, Discharge Date:	MM/DD/YY
☐	Psychiatric Hospital, Discharge Date	MM/DD/YY
☐	PCP, Last visit date:	MM/DD/YY

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
- ☐ Ambulatory with assistive device (Cane, Walker)
- ☐ Confined to Wheelchair
- ☐ 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 Support(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's 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	MM/DD/YY

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