



# Managed Long Term Services & Supports Referral



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Referral Source: \_\_\_\_\_ Date of Referral: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## Internal to L.A. Care:

- ☐ Case Management ☐ Utilization Management ☐ Social Worker ☐ Behavioral Health  
☐ Customer Solutions Center ☐ Other (specify): \_\_\_\_\_

## External:

- ☐ Member/Family/Caregiver ☐ Provider ☐ Hospital ☐ SNF ☐ Pharmacy ☐ PPG/IPA: \_\_\_\_\_  
☐ Community Based Organization ☐ CBAS ☐ MSSP ☐ Vendor ☐ Other (specify): \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone and extension: \_\_\_\_\_

Member is currently: ☐ In a nursing facility under skilled care ☐ Acute hospital ☐ N/A

(Referral MUST be completely filled out or referral will be declined and returned to referral source.)

If member is inpatient, please complete Utilization Management Authorization Request Form which can be found on our website: [http://www.lacare.org/sites/default/files/la1988\\_authorization\\_request\\_form\\_0718.pdf](http://www.lacare.org/sites/default/files/la1988_authorization_request_form_0718.pdf)

## SECTION I: Member information

Member Name: \_\_\_\_\_ Gender: ☐ M ☐ F D.O.B: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_

CIN: \_\_\_\_\_ Current Address: \_\_\_\_\_ Language: \_\_\_\_\_

LOB: ☐ MCLA ☐ CMC City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Authorized Representative: \_\_\_\_\_ Consent to speak to AR: ☐ Yes ☐ No Phone: \_\_\_\_\_

## SECTION II: Clinical information

Diagnosis: \_\_\_\_\_

Currently enrolled in L.A. Care Case Management Program?

☐ Yes ☐ No Case Manager: \_\_\_\_\_ Ext. \_\_\_\_\_

Has member recently been admitted to:

☐ Emergency Room ☐ Hospital ☐ SNF ☐ Discharge Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Member's general condition (check all that apply):

- ☐ Ambulatory ☐ Ambulatory with assistance ☐ Maximum assist with all ADL's/IADL's ☐ Confined to bed  
☐ Confined to wheelchair ☐ Incontinent ☐ Other (specify): \_\_\_\_\_

Current Social Supports (check all that apply):

- ☐ None ☐ Lives alone, but has outside support ☐ Lives with Partner/Spouse/Family  
☐ Resides in group home/B&C/Assisted Living/Senior Living/Etc. ☐ Has unpaid caregiver assistance  
☐ Receives IHSS ☐ Other (specify): \_\_\_\_\_

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

## SECTION III: Requested MLTSS Service(s)

### ☐ Long Term Care (LTC) Nursing Facility

*\*Please check all that apply AND complete summary section on page 1*

#### Reason for LTC Diversion Referral:

- ☐ Be at home, at risk in community
- ☐ Needs 24 hr. care/assistance with ADLs
- ☐ Other (specify): \_\_\_\_\_

### ☐ In Home Supportive Services IHSS

*\*Please check all that apply AND complete summary section on page 1*

#### Member must:

- ☐ Be age 65 years of age or older, or blind or disabled
- ☐ Meet Medi-Cal eligibility criteria
- ☐ Have a disability that will last 12 months or longer
- ☐ Not live in a Board and Care, SNF or Assisted Living Facility

#### AND

- ☐ Unable to perform activities of daily living independently at risk of institutionalization

#### Reason for IHSS Referral:

- ☐ Initial application
- ☐ Increase in hours
- ☐ Issues regarding time sheets
- ☐ Change in Provider/Caregiver
- ☐ Re-evaluation/Change in health status
- ☐ Denied services/Needs assistance with G&A process
- ☐ Other (specify): \_\_\_\_\_

### ☐ Multipurpose Senior Services Program (MSSP)

*\*Please check all that apply AND complete summary section on page 1*

#### Member must:

- ☐ Be 65 years of age or older
- ☐ Be currently eligible for Medi-Cal
- ☐ Be certified or certifiable for placement in a nursing facility

#### Reason for MSSP Referral:

- ☐ Initial application
- ☐ Other (specify): \_\_\_\_\_

### ☐ Care Plan Options (CPO)

*\*Please check all that apply AND complete summary section on page 1*

#### Have community resources been accessed already?

- ☐ Yes ☐ No

#### Member must:

- ☐ Be enrolled in Cal MediConnect (CMC)

### ☐ Community Based Adult Services (CBAS)

*\*Please check all that apply AND complete summary section on page 1*

#### Member must:

- ☐ Be 18 years or older and have Medi-Cal with L.A. Care

#### AND one or more of the following:

- ☐ At risk for nursing facility placement
- ☐ An organic, acquired or traumatic brain injury, and or chronic mental disorder AND needs assistance with activities of daily living
- ☐ Mild to severe cognitive disorder
- ☐ Mild cognitive disorder such as dementia AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication, management, or hygiene
- ☐ Developmental Disability

#### Reason for CBAS Referral:

- ☐ Initial request
- ☐ Increase in days
- ☐ Request to change CBAS center
- ☐ Other (specify): \_\_\_\_\_

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