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)

Provide a brief summary of the Member's current Recuperative Care needs:

_____

_____

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 Information

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

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

Member's Phone Number: _____

Member's Contact Preference: ☐ Phone ☐ Email

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.**

Member's Current Location*

☐ Shelter ☐ Clinic ☐ Home ☐ Hospital ☐ Emergency Department

☐ Interim Housing ☐ LTC ☐ Recuperative Care ☐ Community ☐ Street Medicine

☐ Correctional Facility ☐ Behavioral Health Unit ☐ Other: _____

Name of current location: _____

Address of current location: _____

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

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

If member is in Recuperative Care Facility provide Date of Admission: _____/_____/_____

L.A. Care HEALTH PLAN®

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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 ☐ SNF ☐ PCP ☐ PPG ☐ Recup
Other: _____

Referring Individual Name:* _____
Referring Organization Name:* _____
Referrer Phone Number: * _____
Referrer Fax Number:* _____
Referrer Email Address:* _____
Alternative Contact Name:* _____
Alternative Contact Phone Number:* _____

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

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 discharge? ☐ Yes ☐ No

17 Is the member psychiatrically stable for discharge? ☐ Yes ☐ No

18 Does member require Dialysis? ☐ Yes ☐ No

Name of Dialysis Facility: _____ Phone Number of Dialysis Facility: _____

Chair Time: _____ Weekly Schedule: _____

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 more information on L.A. Care contracted Recuperative Care facilities, please visit our website by clicking here.

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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.

Referring entities can work directly with a L.A. Care contracted Recuperative Care Facility. When working directly with a Recuperative Care Facility you do not need to submit a duplicative referral directly to L.A. Care. You do not need to send L.A. Care any additional clinical documentation, unless the Recuperative Care Facility is unable to accept your referral and you chose to have L.A. Care assist with your request. For a list of L.A. Care Recuperative Care Providers, please click here.