EAA SAR 2022 P1

Environmental Accessibility Adaptations (EAA)

Service Authorization Request Form

Fax to 1-213-985-1835

L.A. Care Health Plan offers Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) for eligible members to ensure their health, welfare, and safety at home. MD order required.

Member information

Member Number | Member DOB (M M / D D / Y Y Y Y) | 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 Contact information & Official Designation Title

First Name | Last Name

Phone Number | Title/Relationship

☐ Checking this box simply attests that treatment has been discussed and have received "Member Consent" to proceed with a Service Authorization Request (SAR) for covered benefits and services that require medical necessity review and approval prior to scheduling any appointment.

Requesting/Prescribing/Facility Information

Requesting/Prescribing/Facility NPI | Phone | Fax

Requesting/Prescribing/Facility Name

Requesting/Prescribing/Facility Address

Requesting/Prescribing/Facility City | Zip | LAC Provider ID

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

Request Type:

☐ Initial Request

☐ Continuation of Services (unable to complete home modifications within authorization period) LAC Auth#

Reason:

Eligibility Criteria-Please check every box applicable

☐ Active Enrollment in L.A. Care's Medi-Cal HMO Plan; **AND**

☐ Clinical Documentation from Primary Care Physician (PCP) or Specialist which supports Medical necessity required for an EAA Service Authorization Request (SAR); **AND**

☐ If for PERS, Member lacks caregiver support or supervision; **OR**

☐ If for PERS, Home alone or unattended for significant periods of time at home;

If you answered yes to each of the items above and you are able to include clinical documentation at this time, please complete this entire Service Authorization Request (SAR) for EAA services and send via secure fax to the Managed Long Term Services and Supports (MLTSS) department.

Request Priority (if left blank will be processed as Routine)

☐ Routine

☐ Expedited ☐ Member discharging from Hospital/LTACH/SNF

☐ Member faces serious or imminent threat to his/her health

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L.A. Care HEALTH PLAN

Requested Environmental Accessibility & Adaption (EAA) Services

Is requested service a Medi-Cal benefit (DME)? ☐ Yes ☐ No If yes, please re-direct this request to PCP or treating doctor

Continuity of Care

Have you had any previous home modifications or PERS approved from other health plans?

☐ Yes Please indicate the Health Plan name:

☐ No

Requested Home Modifications EAA Services require an MD order and supporting documentation relating to Medical Necessity and how EAA will benefit the member.

- ☐ Custom made ramps to assist Member in accessing the home
- ☐ Custom made grab bars
- ☐ Doorway widening (Internal or External doors)
- ☐ Mechanical Stair lifts
- ☐ Safeway Step
- ☐ Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)
- ☐ Installation of specialized electric or plumbing systems that are necessary to accommodate the Member's medical equipment/supplies
- ☐ Other
- ☐ Other
- ✔ Other

PERS (Personal Emergency Response System)

Homebound ☐ Yes ☐ No

Clinical Information

Known Cognitive Impairment: ☐ Yes ☐ No

Does the member have cognitive issues where they would not use the PERS appropriately? ☐ Yes ☐ No

Recent change in condition: ☐ Yes ☐ No

If Yes, Type of Change in Condition: ☐ Cognitive decline ☐ Functional limitation ☐ Increased weakness ☐ Pain ☐ Shortness of breath ☐ Other

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 M M / D D / Y Y ☐ No

Home Health services for skilled needs:

☐ PT ☐ OT ☐ ST ☐ Nursing ☐ Other

Member's 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: M M / D D / Y Y
- ☐ 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)

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Current Social Supports (check all that apply):

- ☐ None
- ☐ 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 should include:**

- MD order must be attached.
- If this is a part of a discharge plan from an acute facility or SNF, please attach H&P and DC Plan.
- Latest MD visit notes with diagnoses, conditions, medications, treatment orders.
- PT/OT/DME evaluation documenting safety needs.
- Any assessments documenting member's physical needs and identification of need for EAA services or equipment.
- If recently discharged from Hospital, Skilled Nursing or Long Term Care, Please attach DC summary.