Community Supports – Approval Request Form
(*for Nursing Facility Transition/Diversion to Assisted Living Facilities AND Community Transition Services/Nursing Facility Transition to Home*)

The Alameda Alliance for Health (Alliance) Community Supports (CS) Department – Nursing Facility Transition/Diversion to Assisted Living Facilities AND Community Transition Services/Nursing Facility Transition to Home Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may need CS nursing facility transition/diversion to assisted living facilities and community transition services/nursing facility transition to home services, please complete the form below. Approval is based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all the fields below.
2. Attach a clinical summary and/or supporting documentation (ex. clinic notes from the current facility, other documentation of member's facility stay, etc.), to justify nursing facility transition/diversion to assisted living facilities and community transition services/nursing facility transition to home services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Office Contact Name: _____ Today's Date: _____

☐ Referred by Clinician (RN, MD, PCP, NP, etc.) Date of Service: _____

Level of Urgency (please select only one (1): ☐ Routine ☐ Urgent ☐ Retro

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Primary Diagnosis Requiring Diversion or Transition to Home (including ICD-10 Code(s)):

_____

☐ Confirm (to the best of your knowledge) the member is not receiving duplicative support from other state, local, or federally funded programs, and these programs have been considered first before using Medi-Cal funding.

Is an interpreter needed?

☐ Yes

If yes, what is the preferred language? _____

☐ No

Is the member currently linked to a case management team?

☐ Yes

Case Manager/Team Name: _____

Phone Number: _____

☐ No

Is the member participating in or well-linked with other case management services?

☐ Yes

☐ No

Please describe the member's current case management situation:

Patient's Qualifying Condition(s) (please select all that apply and provide supporting documentation. The patient must meet all qualifying conditions in the column to be eligible):

	Diversion		**Transition to a Home**
	For Nursing Facility Transition	For Nursing Facility Diversion	
Currently receiving medically necessary nursing facility level of care (LOC)		☐	☐
Resided 60+ days in a nursing facility	☐		☐
Interested in moving back to the community		☐	☐
Able to reside safely in the community with appropriate and cost-effective support and services	☐	☐	☐
Willing to live in an assisted living setting as an alternative to a nursing facility	☐		

Requesting Services (please select one (1)**:**

- ☐ Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for elderly and adult residential facilities (please select one (1)):
  - ☐ Nursing facility transition
  - ☐ Diversion to assisted living facility
- ☐ Community transition services/nursing facility transition to a home

Rendering Provider (please select only one (1)):

- ☐ East Bay Innovations (EBI) (NPI Number: 1699002634)
- ☐ Omatochi (NPI Number: 1669058558)