Long-Term Care – Request for Referral Form (RRF)

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department Request Referral Form (RRF) is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please fax the completed form to the Alliance Long-Term Care (LTC) Department at **1.510.747.4191**.

For questions, please call the Alliance LTC Department at **1.510.747.4516**.

PLEASE NOTE: Incomplete forms may be delayed or declined and returned to the referral source. If the member is inpatient, please complete the Alliance Utilization Management (UM) **Prior Authorization Request Form** also available on the Alliance website or provider portal at **www.alamedaalliance.org**.

SECTION 1: REFERRAL INFORMATION

Date of Referral (MM/DD/YYYY): _____

Referral Source *(please select only one (1)*:

☐ **Internal to the Alliance** *(please select only one (1)*:

- ☐ Behavioral Health
- ☐ Case Management
- ☐ Community Supports
- ☐ Customer Solution Center
- ☐ Enhanced Care Management
- ☐ Social Worker
- ☐ Utilization Management
- ☐ Other: _____

☐ **External from the Alliance** *(please select only one (1)*:

- ☐ Community-Based Adult Services (CBAS)
- ☐ Community-Based Organization (CBO)
- ☐ Hospital
- ☐ Member/Family/Caregiver
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Participating Physician Group (PPG)/ Independent Physician Association (IPA)
- ☐ Pharmacy
- ☐ Provider
- ☐ Skilled Nursing Facility (SNF)
- ☐ Vendor
- ☐ Other: _____

Referred By: _____ Phone Number (Ext.): _____

Member is currently:

- ☐ In a nursing facility under skilled care
- ☐ In an acute hospital
- ☐ N/A

SECTION 2: MEMBER INFORMATION

MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Language: _____ Gender: ☐ Male ☐ Female

Alliance Member ID #: _____ Client Identification Number (CIN): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Line of Business: ☐ Group Care ☐ Medi-Call

AUTHORIZED REPRESENTATIVE (AOR) INFORMATION

Last Name: _____ First Name: _____

Phone Number: _____ Consent to speak to AOR: ☐ Yes ☐ No

Primary Language: _____ Request for interpreter: ☐ Yes ☐ No

SECTION 3: CLINICAL INFORMATION

Diagnosis: _____

Member currently enrolled in an Alliance Case Management Program: ☐ Yes ☐ No

Case Manager Last Name: _____ Case Manager First Name: _____

Phone Number (Ext.): _____ Fax Number: _____

Member has recently been admitted to *(please select all that apply)*:

☐ Emergency room
☐ Hospital
☐ SNF

Most Recent Discharge Date (MM/DD/YYYY): _____

Member's General Condition *(please select all that apply)*:

☐ Ambulatory
☐ Ambulatory with assistance
☐ Confined to a bed
☐ Confined to a wheelchair
☐ Incontinent
☐ Maximum assistance with all ADLs/IADLs

☐ Other (specify): _____

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

SECTION 4: REQUESTED SERVICE(S)

Requested Managed Long-Term Services and Supports (MLTSS) Services *(please select only one (1))*:

- ☐ Long-Term Care (LTC) Nursing Facility *(please select all that apply **and** complete **Section 1: Referral Information** on **page 1**)*:
  - ☐ Be at home, at risk in the community
  - ☐ Needs 24-hour care/assistance with ADLs
  - ☐ Other (specify): _____
- ☐ Community-Based Adult Services (CBAS) *(please see below **and** complete **Section 1: Referral Information** on **page 1**):*
  *Member must be 18 years or older, be an Alliance Medi-Cal member, **and*** have one (1) or more of the following:
  - ☐ At risk for nursing facility placement
  - ☐ Developmental disability
  - ☐ Mild cognitive disorder such as dementia ***and*** need assistance or supervision with two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication, management, or hygiene
  - ☐ Mild to severe cognitive disorder
  - ☐ Organic, acquired, or traumatic brain injury, and or chronic mental disorder ***and*** needs assistance with activities of daily living

Reason for CBAS Referral:

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