

# Assisted Living Facility (ALF) Transitions Referral Form

Assisted Living Facility (ALF) Transitions (formerly known as “Nursing Facility Transition/Diversion to Assisted Living Facilities,” such as residential care facilities for the elderly and adult residential facilities) is designed to assist individuals with living in the community and avoiding institutionalization whenever possible. For more information, review the [Assisted Living Facility Transitions Authorization Guide](#).

Complete and submit this referral form with the [Medi-Cal – Prior Authorization Request Form – Outpatient](#) either online (recommended) at [provider.healthnetcalifornia.com](http://provider.healthnetcalifornia.com) or by fax at 800-743-1655.

Select One: <input type="checkbox"/> Initial request <input type="checkbox"/> Extension request	
Select One: <input type="checkbox"/> Transition from a nursing facility (from facility to ALF). <input type="checkbox"/> Remain in community (from community to ALF).	
<input type="checkbox"/> Member consented to Assisted Living Facility Transitions referral. <input type="checkbox"/> Member acknowledges responsibility for paying their own living expenses (room and board).	
<b>Member information</b>	
Member name:	Date of birth (DOB):
Medi-Cal ID:	Preferred language:
Home address:	Phone number:
Contact name (if different than member):	Relationship:
Phone number:	Preferred language:
Member’s need for transition services (initial or extension request):	

Eligibility criteria	
Member must meet <u>all</u> the following criteria:	
<b>Members residing in a nursing facility who:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Has resided 60+ days in a nursing facility.</li> <li><input type="checkbox"/> Is willing to live in an assisted living setting as an alternative to a nursing facility.</li> <li><input type="checkbox"/> Can reside safely in an ALF.</li> </ul>	<b>Members residing in the community who:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Is interested in remaining in the community.</li> <li><input type="checkbox"/> Is willing and able to reside safely in an ALF.</li> <li><input type="checkbox"/> Meet the minimum criteria to receive nursing facility LOC services<sup>1</sup> and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.</li> </ul>
Required documents	
Submit documents with the Referral Form.	
<b>Initial authorization:</b> <b>Transition from a nursing facility (from facility to ALF):</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Admission face sheet</li> <li><input type="checkbox"/> Individual plan of care</li> <li><input type="checkbox"/> Copy of Assisted Living Waiver (ALW) application (if member has applied for ALW)</li> </ul> <b>Remain in community (from community to ALF):</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Documentation of authorization for Community-Based Adult Services (CBAS) or</li> <li><input type="checkbox"/> Documentation of authorization for In-Home Supportive Services (IHSS) or</li> <li><input type="checkbox"/> Documentation of enrollment in Long-Term Services and Supports (LTSS) or a qualified waiver program or</li> <li><input type="checkbox"/> Medical provider order for nursing facility level of care</li> </ul>	<b>Extension request (reauthorization):</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Reason for authorization extension</li> <li><input type="checkbox"/> Individual plan of care</li> <li><input type="checkbox"/> Status of ALW application (if member has applied for ALW)</li> </ul>
Assisted living facility information	
Facility name:	
Facility address:	
Tax ID:	National provider identifier (NPI):

<sup>1</sup>Nursing facility level of care as defined in Section 51124 of Title 22 of the California Code of Regulations.

Is the facility part of the ALW Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, explain why the member is not placed at an ALW facility.	
<b>Tier<sup>2</sup> – Level of care requested (based on the assessment):</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 (Members in Tier 5 may have extensive care needs beyond what the ALF can provide.)	
Staff name:	Title:
Phone number:	Fax number:
<b>Community Support provider information (servicing organization)</b>	
<input type="checkbox"/> Check this box if the ALF is the same as Community Support provider.	
Organization name:	
Tax ID:	NPI:
Staff name:	Title:
Phone number:	Fax number:
<b>Referral information (referring entity)</b>	
<input type="checkbox"/> Check this box if the referring entity is the same as the Community Support provider.	
Name:	
Address:	Phone number:
Email address:	Fax number:

<b>Time-limited transition services and expenses</b>
<p>Time-limited transition services and expenses to enable a person to establish a residence in an ALF.          Transition services end once the member establishes residency in the ALF.</p> <p>Please check each box the member is requesting for assistance and provide the required documents.</p>

<sup>2</sup>Per [www.dhcs.ca.gov/services/ltc/Documents/ALW-Renewal-2019-2024-Approved.pdf](http://www.dhcs.ca.gov/services/ltc/Documents/ALW-Renewal-2019-2024-Approved.pdf): Assisted Living Services will be delivered to participants in one of five possible "tiers" of service. Participants will be assigned an ALW tier as determined by the Care Coordination Agency RN. ALW Assessment Tool is administered by the CCA RN to potential, new participants to the waiver, and repeated at each reassessment. The tool measures the need for assistance with ADLs, IADLs and the need for assistance in one or more of the seven functional categories: Cognitive Patterns, Behavioral Symptoms, Continence, Communications, Medications, Skin Conditions, or Other Treatments. Based on the combined need for assistance in these areas, the tool calculates a LOC eligibility and tier of service for the participant.

- Tier one services will be assigned to participants with the lowest level of support need.
- Tier two, tier three, and tier four services will be assigned to participants with more significant support needs, respectively; and;
- Tier five services will be assigned to participants who require intense, focused attention to ADLs and IADLs as a result of a severe traumatic brain injury. These participants will have a need for assistance beyond that provided in tiers one through four along with the additional residential habilitation services to successfully manage their care needs while residing in either an RCFE/ARF or PSH.

Requested items		Amount request
<b>Moving expenses</b> Rental payment as required by landlord for occupancy. Limits may apply.		
<input type="checkbox"/> Movers (Max \$1,000)	<input type="checkbox"/> Quote-service cost	
<input type="checkbox"/> Moving supplies (boxes, tape, bubble wrap, etc.)	<input type="checkbox"/> Quote-service cost	
<b>Utilities</b> Deposit/bill needed to be paid to establish utility service upon move in. No allowance maximum.		Amount request
<input type="checkbox"/> Utilities (Wi-Fi, electricity, etc.)	<input type="checkbox"/> Utility bill (must include all pages and the member's name must match).	
<b>Cleaning services</b> Services necessary for the individual's health and safety, such as one-time pest eradication and one-time cleaning prior to occupancy.		Amount request
<input type="checkbox"/> Fumigation	<input type="checkbox"/> Quote-service cost	
<input type="checkbox"/> Cleaning	<input type="checkbox"/> Quote-service cost	
<b>Medically necessary adaptative aids</b> If the member's Medi-Cal health plan/delegated medical group has denied durable medical equipment (DME), submit request and provide DME denial letters as a supporting document.		
<input type="checkbox"/> Hoyer lift	<input type="checkbox"/> Medi-Cal DME denial letter. <input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Hospital bed	<input type="checkbox"/> Medi-Cal DME denial letter. <input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Shower chair	<input type="checkbox"/> Medi-Cal DME denial letter. <input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Bedside commode	<input type="checkbox"/> Medi-Cal DME denial letter. <input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	

<b>Fall risk prevention items (mandatory purchase)</b>		<b>Amount request</b>
Items that increase safety and minimize the likelihood of falls.		
<input type="checkbox"/> Bath mat	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Non-skid socks (12 pack)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<b>Approved items</b>		<b>Amount request</b>
Items designed to preserve an individual's health and safety in the home that are necessary to ensure access and safety for the individual upon moving into the home. Maximum allowances include taxes. Costs that exceed the maximum will be denied.		
<input type="checkbox"/> Twin bed frame (Max \$200)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Mattress (Max \$350)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Television (Max 42 in.)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> TV stand (One max)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Nightstand (One max)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Lamp (One nightstand lamp and one room lamp max)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Dining table and 2 chairs (Max \$300)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Mini Refrigerator (if not provided/if allowed by ALF) (Max \$800)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<input type="checkbox"/> Microwave (if not provided/if allowed by ALF) (Max \$125)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	

Approved items, <i>continued</i>		Amount request
<input type="checkbox"/> General home goods (i.e. bathroom items, towels, dishware, bedding/linens, etc.) (Max \$600 for all items)	<input type="checkbox"/> Receipts do not need to be submitted to the Plan but must be kept in the member's records for auditing purpose.	
<b>Total amount requested (please round all costs up to the nearest full dollar amount):</b> Maximum allowance including taxes, shipping and delivery charges must not exceed \$6,000.		

**Additional comments:**