

## Long-Term Services and Supports Assessments Request Form

**Phone: 714-246-8444 Fax: 714-246-8843**

**Fax this form to CalOptima LTSS department**

<b>Requestor Info</b>	
Requester Name: _____ Title: _____	
Phone Number: _____ Fax Number: _____	
Email: _____	
HMO/Health Network Name: _____	
NPI #: _____	
Signature: _____ Date: _____	
<b>Member Info</b>	
Patient Name: _____	
Date of Birth: ____/____/____ CIN #: _____	
Primary Care Provider: _____	
Member Eligibility Date: ____/____/____ HMO/Health Network Name: _____	
<p><b>Please attach member's eligibility computer screenshot showing eligibility date and HMO/HN affiliation, or a copy of signed and dated member's authorization for release of medical records,</b></p>	
<b>Types of Record Requested</b>	
<p style="text-align: center;"><b><u>Nursing Facility (NF)</u></b></p> <p><input type="checkbox"/> NF Minimum Data Set (MDS)</p> <p><input type="checkbox"/> NF Case Conference Notes</p> <p><input type="checkbox"/> NF MD Orders and Progress Notes</p> <p><input type="checkbox"/> NF Nursing Progress Notes</p> <p><input type="checkbox"/> NF Treatment Notes</p> <p><input type="checkbox"/> NF Care Plan</p>	<p style="text-align: center;"><b><u>Community-Based Adult Services (CBAS)</u></b></p> <p><input type="checkbox"/> CBAS Eligibility Determination Tool (CEDT)</p> <p><input type="checkbox"/> CBAS Individual Plan of Care (IPC)</p>
<p style="text-align: center;"><b><u>Multipurpose Senior Services Program (MSSP)</u></b></p> <p><input type="checkbox"/> MSSP Health Assessment</p> <p><input type="checkbox"/> MSSP Initial Psychosocial Assessment</p> <p><input type="checkbox"/> MSSP Reassessment</p> <p><input type="checkbox"/> MSSP Care Plan</p>	<p style="text-align: center;"><b><u>In-Home Supportive Services (IHSS)</u></b></p> <p><input type="checkbox"/> IHSS Assessment Summary</p>