CS Assisted Living Facility Transition Services
All Counties
Version 2

Assisted Living Facilities (ALF) Community Supports assist members with a need for nursing facility level of care (LOC) who may be able to live safely in a home-like community setting as an alternative to long-term placement in a nursing facility. For this service, Assisted Living Facilities include Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF).

Assisted Living Facilities Community Supports may support nursing facility transition or nursing facility diversion. Members are directly responsible for paying their own living expenses.

Send the completed referral via secure email: MHC_CS@MolinaHealthcare.com or fax to: (833) 305-3130.

All fields with an * are required.

SECTION 1 – REFERRAL INFORMATION

Referral Date	
Referral Type	☐ Community Referral ☐ Identified by Molina ☐ Self-Referral ☐ Other:
Referring Organization Name	
Referring Organization NPI	
Referring Individual First Name*	
Referring Individual Last Name*	
Referring Individual Relationship to Member*	
Referring Individual Phone Number*	
Referring Individual Fax Number*	
Referring Individual Email Address*	

SECTION 2 – MEMBER INFORMATION

Member First Name*	
Member Last Name*	
Date of Birth*	
Medi-Cal CIN	
Preferred Written Language	
Member Email Address	
Member Primary Phone Number	
Member Residential Address	

City	
State	
Zip Code	
Is the member currently experiencing homelessness?	☐ Yes ☐ No ☐ Unknown

SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION

Member has Authorized Representative	☐ Yes ☐ No
Authorized Representative First Name	
Authorized Representative Last Name	
Authorized Representative Relationship to Member	
Phone Number	
Email Address	
Mailing Address	

SECTION 4 – CLINICAL INFORMATION

Primary Diagnosis	
ICD-10 Code	
Secondary Diagnoses	
Primary Care Provider	
Behavioral Health Provider (if applicable)	
Recent Hospitalization Within Past 30 Days	☐ Yes ☐ No
If Yes, Discharge Date	

SECTION 5 – SERVICE INFORMATION

Request Information

Service Start Date:

Service End Date:

Eligibility Criteria

Molina Enrollment:

☐ Enrolled in Medi-Cal with Molina

Member must meet one of the following pathways:

Nursing Facility Transition

☐ Member is being referred for Nursing Facility Transition and meets the criteria below:

☐ Member has resided 60 or more days in a nursing facility.

☐ Member is willing to live in an assisted living setting as an alternative to long-term placement in a nursing facility.

☐ Member is able to reside safely in an assisted living setting with appropriate and cost-effective supports and services.

OR

Nursing Facility Diversion

☐ Member is being referred for Nursing Facility Diversion and meets the criteria below:

☐ Member is interested in remaining in the community or transitioning to an assisted living setting rather than entering a nursing facility.

☐ Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services.

☐ Member is receiving medically necessary nursing facility level of care (LOC) or meets the minimum criteria to receive nursing facility LOC services and, in lieu of long-term nursing facility placement, is choosing to receive medically necessary nursing facility LOC services in an assisted living facility.

Current Placement / Facility Information

Current Facility or Residence Name:

Current Facility or Residence Address:

City:

State:

Zip Code:

Facility / Residence Contact Name:

Title:

Phone Number:

Fax Number:

Email Address:

SECTION 6 – REQUIRED DOCUMENTATION

Please attach all supporting documentation required for review.

☐ Nursing Facility Level of Care Documentation

☐ Discharge Planning Documentation, if applicable

☐ Clinical Documentation Supporting Service Need

☐ Supporting Documentation Demonstrating Member Can Safely Reside in an Assisted Living Setting

☐ Additional Supporting Documentation

Additional documentation submitted:

SECTION 7 – ATTESTATION

Member Consent

☐ I attest that the member and/or authorized representative has consented to this Community Supports referral.

Referral Attestation

☐ I attest that the information provided in this referral is accurate and complete to the best of my knowledge.