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| **ALTCS ETI Form** |

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| **Sending PC:** |  | **Receiving PC:** |  |
| **Transition Date:** |  | **Rate Code:** |  |
| **Primary Language Spoken:** |  | [ ] **M or** [ ] **F**  |  |  |  |
| **Contact Person / Relationship:** |  |  |  |
|  |  |  | ***(Indicate if Guardian, POA, etc.)*** |
| **Contact Person Phone #:** |  |  |  |

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| **Primary Health Insurance** |

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| **Medicare #:** |  |  | **Part** [ ] **A** [ ] **B** [ ] **D**  |
| **Medicare Advantage -PDP:** |  | **SNP?** | [ ] YES | [ ] NO |
| **PDP:** |  |  | **Other:** |  |
|  |
| **Member Location** |
| **Current Address:** |  |
| **Phone Number:** |  |
| **Facility Name *(if applicable)*:** |  |
| **Type of Facility:** | **Skilled Nursing Facility** | **Assisted Living Facility** | **Behavioral Health** |
| **Admission Date:** |  |  | **Specialty Unit:** |  |
| **Level of Care:** |  |  | **ALF Room and Board Amount:** |  |
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| **Medical Information** |
| **Diagnoses:** |  |
| **PCP Name:** |  |  | **PCP Phone** #: |  |
| **Specialists** ***(Including out of area)*** |
| **Name:** |  | **Type:** |  | **Phone #:** |  |
| **Name:** |  | **Type:** |  | **Phone #:** |  |
| **Scheduled appointments/procedures:** |  |
|  |
| **Special Medications/Treatments:** |  |
|  |
| **CRS Services:** |  |
| **Pending Physicians orders not yet completed:** |  |
|  |

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| **Dialysis** |

|  |  |
| --- | --- |
| **Site Name and Address:** |  |
| **Days:** [ ] **M** [ ] **T** [ ] **W** [ ] **Th** [ ] **F** [ ] **Sat** [ ] **Sun Time:** |  | **Phone Number:** |  |
| **Transportation Provided by:** |  |
| **Assistance and/or Type of Transportation Required:** |  |
|  |

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| **DME/Supplies** (see attached information for additional details on DME/Supplies as needed) |
| **DME:** |  | **Rented?** | **Owned?** | **Provider:** |  |
| **DME:** |  | **Rented?** | **Owned?** | **Provider:** |  |
| **DME:** |  | **Rented?** | **Owned?** | **Provider:** |  |
| **DME:** |  | **Rented?** | **Owned?** | **Provider:** |  |
| **Supplies Needed:** |  | **Provider:** |  |
| **Supplies Needed:** |  | **Provider:** |  |
| **Supplies Needed:** |  | **Provider:** |  |
|  |  |  |  |
| **Pending Issues requiring follow-up:** |  |
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| **Pending Grievance?** | [ ]  **Yes** | [ ]  | **No** | **Expected Resolution Date:** |  |
| **What is nature of grievance?** |  |
|  |
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| **Hospitalized Members  *(complete if member is hospitalized on date form is completed)*** |
| **Hospital:** |  | **Phone:** |  |
| **Admission Date:** |  | **Admitting Diagnosis:** |  |
| **Inpatient Treatments:** |  |
| **Expected Discharge Date:** |  | **D/C** **To:** |  |
|  |  |  |  |
| **Other Comments:** |  |
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| **Dental Benefit *(Complete For All Members))*** |

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| **ALTCS Routine Dental Benefit Used:** | **$**  |  |  |

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| --- | --- | --- | --- |
| **Emergency Dental Benefit Used:** | **$**  |  |  |

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| **HCBS Services** ***(Check all that apply or attach Service Authorizations for details)*** |

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| **Adult Day Health** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Attendant Care** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Home Delivered Meals** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Homemaker** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Personal Care** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Respite** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Other \_\_\_\_\_\_\_\_\_\_\_** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| [ ]  **Emergency Alert** | **Provider** |  | **Phone#:** |  |  |  |

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| [ ]  **Home Health Nursing** | **Provider:** |  | **Frequency:** |  |
| **Phone#:** |  |
| **Payer Source:** |  |
| [ ]  **Home Health Aide** | **Provider:** |  | **Frequency:** |  |
| **Phone#:** |  |
| **Payer Source** |  |
| [ ]  **Hospice** | **Provider:** |  | **Frequency:** |  |
| **Phone#:** |  |
| **Payer Source:** |  |

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| **Behavioral Health** |
| **BH Diagnosis:** |  |
| **BH Medications:**  |  |
|  |  |
|  |  |
| **BH Services/Providers:** |
| **Service** | **Provider** | **Phone #** | **Frequency** |
|  |  |  |  |
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| **Last Date of Judicial Review:**  |  | **Outcome:**  |  |
|  |  |  |  |  |  |
|  | [ ]  **COT** |  | **Name on Court Order:** |  | **Expiration Date:** |  |

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| **Required Attachments and Other Transitioning Information:** |

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| [ ]  **Last CM Assessment** | [ ]  **CM Summary**  |
| [ ] **Last Quarterly Behavioral Health Consult, if** **applicable** | [ ] **Advanced Directives (Living wills, Powers of Attorney,** **etc.), if applicable** |
| [ ] **List of Medications** | [ ] **EPSDT Forms, if applicable** |
| [ ] **Contingency Plan, if member receiving critical services** | [ ] **Guardian/Conservatorship or Power of Attorney, if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| [ ] **Out-Pt Adult Physical Therapy Service. The number of visits received for current contract year**  | [ ] **Lifetime use of Community Transition Service (CTS)** |
| [ ] **Respite Hours Utilized** | [ ] **Benefit Community Transition ServiceDate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| [ ] **Inpatient Days Utilized** |  |

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|  |  |  |  |  |
| ***Case Manager Name*** |  | ***Phone*** |  | ***Date*** |