Lutheran Social Service of Minnesota's Healthy Transitions (Post-Discharge CHW) Authorization Request Form (MSHO only)

Use this form to authorize the **Healthy Transitions (Post-Discharge Community Health Worker)** service for MSHO members. *All MSHO members are eligible for this supplemental benefit. This service does not count towards the member's Elderly Waiver budget. Incomplete, illegible, or inaccurate forms will be returned to the Care Coordinator.

- This form can only be completed by a UCare Care Coordinator.
- **Care coordinator must email or fax this form to BOTH:**
  - UCare Clinical Intake at CLSintake@ucare.org (fax: 612-884-2185 or 1-866-402-5018)
    AND Lutheran Social Services at lsshealthytransitions@lssmn.org
- For questions about the authorization, call 612-676-6705 or email CLSintake@ucare.org

MEMBER INFORMATION

Name:______________________________ PMI:____________________ UCare ID:____________________

Address:______________________________ City/State/Zip:______________________________

County:________________________ Phone:______________________ DOB:____________________

To schedule visits, contact: Client Emergency Contact Other:_________________

Emergency Contact Name:____ Relationship:__________________

Scheduling Contact Phone:____

Living Alone: _____ Yes _____No

Primary Language:_______________________________________ Interpreter Needed: _____Yes _____No

Interpreter Vendor Name:____________________________________ Preferred Interpreter: ___________________

AUTHORIZATION INFORMATION

Assigned Care Coordinator:____ Referral Date:____________________

Care Coordinator Email:____ Phone:____________________________

Service Agreement (Service Requested)

Service Description: **S5135 HC @ rate per visit of $165** (approx. one visit per week, up to four weeks)

Start Date: ______________________ End Date: ______________________ (2 months after start date)

Provider: Lutheran Social Service UMPI: A733815500 Phone: 1-888-200-0986

Email or Fax: lsshealthytransitions@lssmn.org or 651-310-9449 ***(for UCare CLS Intake use only)***

Care coordinator must email or fax this form to: CLSintake@ucare.org **and** lsshealthytransitions@lssmn.org.

This form will be processed through UCare CLS Intake and then be forwarded to LSS for follow up. The process may take 5 business days.

HOSPITAL RELEASE INFORMATION

Is Member Discharged? _____Yes ______No _____Unknown

Discharge Date or Estimated Discharge Date from Hospital:______________

Name of Hospital:____ Phone:____________________

Does the member have any upcoming scheduled appointments within 30 days of hospital discharge?

Yes ____ No ____ *If yes, list details: ____

MEMBER ASSESSMENT

Mobility

*Community companion are not able to assist with transfers

Ambulatory Alone

Ambulatory with Cane

Ambulatory with Walker

Wheelchair

Other:_______________________

Cognition

Alert and oriented

Dementia diagnosed

Minor confusion at times

Other:_______________________

Social Support

*Check which supports member currently receives

Family/Friends

PCA/HHA, Homemaker

Home care nurse

ARHMS Worker

Social Worker

Other:_______________________

General Health

Vision Loss, due to:______________

Hearing Loss

Uses Oxygen at Home

Portable Oxygen

COPD

Diabetes

Heart Attack Hx

Chronic Heart Failure

High Blood Pressure

Stroke Hx

Cancer

Anxiety/Depression

Smoking

Joint Replacement

Does member receive waivered services? _____Yes ______No

Does the member currently use a meal delivery service? _____Yes ______No

Additional health information that would be helpful to note for the Community Companion:

Additional notes and recommendation:

LSS OFFICE USE ONLY

Assigned Community Companion:______________________________ Date of first scheduled visit:_____________