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](mailto:CLSintake@ucare.org) (fax: 612-884-2185 or 1-866-402-5018)

**AND** Lutheran Social Services at [lsshealthytransitions@lssmn.org](mailto:lsshealthytransitions@lssmn.org)

* For questions about the authorization, call 612-676-6705 or email [CLSintake@ucare.org](mailto: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

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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](mailto: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](mailto:CLSintake@ucare.org) **and** [lsshealthytransitions@lssmn.org](mailto: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: