MANAGED CARE PLAN REFERRAL TO HOME CARE SERVICES PROGRAM

FROM:			**TO:**	
Name of Plan:			Local Department of Social Services Managed Care Coordinator:	
Address:			Client Identification Number [CIN]:	
Contact Person:	Phone Number:	Date:	Consumer's Emergency Contact Name: Telephone Number:	
Name of PCS Vendor:			PCS Vendor ID:	
Service Level:			Authorized Hours:	
AUTHORIZATION PERIOD:…………………………..→ M11Q Attached: [Y] [N]			From: To:	

The Consumer Listed Above Is Being Disenrolled From Our Plan Effective:
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REASON FOR DISENROLLMENT [If Known – Please include information regarding attempts to complete renewal.]

LDSS USE ONLY

Action Taken:

This case was previously known to LDSS

LDSS authorization provided from: _____________________ to ___________________________

The Case was found to be no longer Medicaid eligible and/or LDSS eligible.

- LDSS application package mailed on ___________________________
- The Case was referred to _______________________________________ on

____

WORKER'S NAME:	WORKER'S SIGNATURE:	DATE:

INSTRUCTIONS TO MANAGED CARE PLANS

1.) Consumers who are no longer eligible to participate in a Managed Care Program and are in receipt of Personal Care benefits, should be referred to the Local Department of Social Services Managed Care Coordinator using this form. Refer only those enrollees whose change in enrollment is effective the current month or the month following the referral (no retrospective disenrollments).

2.) The Managed Care Plan must complete all Sections of the top portion of this form.

3.) If the Managed Care Plan has a current valid medical request, the medical request should be submitted together with this form. A medical request is valid if completed within 30 days of the exam date.