In Lieu of Services (ILOS) Form

Care Coordinator Use Only

Reset Form

Incomplete, illegible, or inaccurate forms will be returned to sender. Allow 7 calendar days for processing of this request.

Email: CareCoordinationReviews@UCare.org

For questions, call: 612-294-5045

In lieu of services (ILOS) may be considered following a member's hospitalization, an outpatient procedure, or anesthesia or when a member may be at risk of hospitalization without the service (s). To be eligible for Chore Services, the member must have a frail health condition, and neither the member nor others in the household can perform the chore.

ILOS Service Request Process:

1. Complete or review the current MnCHOICES Assessment to review eligibility status. If current assessment was completed using DHS-3428 send assessment with ILOS Request.
2. Member may qualify for ILOS when:
   a. Member does not meet nursing facility level of care and has a need for services to prevent ER/hospitalization.
   OR
   b. Member qualifies for EW and has an urgent need for EW services prior to Ucode removal.
3. Care coordinator identifies a DHS-enrolled waiver provider using MinnesotaHelp.info.
4. Complete In Lieu of Services Service Request Form.

Check one of the following:

☐ Member does not qualify for Elderly Waiver and has a need for an ILOS service for 45 days or less.

☐ Member qualifies for Elderly Waiver and has an urgent need for one or more of the following services while Elderly Waiver paperwork is pending.

OR

☐ Denial, Termination or Reduction for ILOS.

Describe the need for ILOS Services. Include related diagnosis.

Explain how members' needs will be met when ILOS services end.

In Lieu of Services (ILOS) Form

MEMBER INFROMATION

Member Name _____ Member ID _____

Date of Birth _____ PMI _____

Phone _____

CARE COORDINATOR

Care Coordinator Name _____ Phone _____

Care Coordinator Email _____ Fax _____

Care Coordination Delegate Name _____

Service Requested

Service Description Select a service

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Provider Name _____ Phone _____

Provider Email Address _____ Fax _____

Provider UMPI or NPI _____

Denial, Termination, Reduction

Service Description Select a service

☐ Denial ☐ Termination ☐ Reduction Reason Code: Select a Reason

Start Date _____ Frequency _____

End Date _____ Total Units _____

Rate Per Unit _____

Provider Name _____

Provider Email Address _____ Phone _____

Provider UMPI or NPI _____ Fax _____

Internal Use Only

Reviewed by: Date Reviewed: Outcome:

Total Amount Authorized ($): Comments: