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:_____

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

Social Support

*Check which supports member currently receives

- ☐ Family/Friends
- ☐ PCA/HHA, Homemaker
- ☐ Home care nurse
- ☐ ARHMS Worker
- ☐ Social Worker
- ☐ Other:_____

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:_____