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| **ALTCS ETI Form** |

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| **Sending PC:** |  | | | | | **Receiving PC:** | |  | | | | | | | |
| **Transition Date:** | |  | | | | **Rate Code:** |  | | | | | | | | |
| **Primary Language Spoken:** | | | |  | | | | | | **M or F** | | |  |  |  |
| **Contact Person / Relationship:** | | | | |  | | |  |  | | | | | | |
|  | | | | |  | | |  | ***(Indicate if Guardian, POA, etc.)*** | | | | | | |
| **Contact Person Phone #:** | | |  | | | | | | | |  |  | | | |

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| **Primary Health Insurance** |

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| **Medicare #:** | |  | | | | | |  | | | **Part A B D** | | | | | | | |
| **Medicare Advantage -PDP:** | | | | |  | | | | | | | **SNP?** | | | YES | | | NO |
| **PDP:** |  | | | | | |  | | **Other:** | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Member Location** | | | | | | | | | | | | | | | | | | |
| **Current Address:** | | | |  | | | | | | | | | | | | | | |
| **Phone Number:** | | |  | | | | | | | | | | | | | | | |
| **Facility Name *(if applicable)*:** | | | | | |  | | | | | | | | | | | | |
| **Type of Facility:** | | | | **Skilled Nursing Facility** | | | | | | **Assisted Living Facility** | | | | | | **Behavioral Health** | | |
| **Admission Date:** | | | |  | | | |  | | | **Specialty Unit:** | | |  | | | | |
| **Level of Care:** | | |  | |  | | | **ALF Room and Board Amount:** | | | | | | | | |  | |
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| **Medical Information** | | | | | | | | | | | | |
| **Diagnoses:** | |  | | | | | | | | | | |
| **PCP Name:** | |  | | | | |  | **PCP Phone** #: | | |  | |
| **Specialists** ***(Including out of area)*** | | | | | | | | | | | | |
| **Name:** |  | | | | **Type:** | | | |  | **Phone #:** | |  |
| **Name:** |  | | | | **Type:** | | | |  | **Phone #:** | |  |
| **Scheduled appointments/procedures:** | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| **Special Medications/Treatments:** | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| **CRS Services:** | |  | | | | | | | | | | |
| **Pending Physicians orders not yet completed:** | | | | | |  | | | | | | |
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| **Dialysis** |

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| **Site Name and Address:** |  | | | | | |
| **Days: M T W Th F Sat Sun Time:** | | |  | | **Phone Number:** |  |
| **Transportation Provided by:** | |  | | | | |
| **Assistance and/or Type of Transportation Required:** | | | |  | | |
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| **DME/Supplies** (see attached information for additional details on DME/Supplies as needed) | | | | | | | | | |
| **DME:** |  | | | **Rented?** | **Owned?** | | **Provider:** | |  |
| **DME:** |  | | | **Rented?** | **Owned?** | | **Provider:** | |  |
| **DME:** |  | | | **Rented?** | **Owned?** | | **Provider:** | |  |
| **DME:** |  | | | **Rented?** | **Owned?** | | **Provider:** | |  |
| **Supplies Needed:** | |  | | | | **Provider:** | |  | |
| **Supplies Needed:** | |  | | | | **Provider:** | |  | |
| **Supplies Needed:** | |  | | | | **Provider:** | |  | |
|  | |  | | | |  | |  | |
| **Pending Issues requiring follow-up:** | | |  | | | | | | |
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| **Pending Grievance?** | **Yes** | |  | **No** | **Expected Resolution Date:** |  |
| **What is nature of grievance?** | |  | | | | | |
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| **Hospitalized Members  *(complete if member is hospitalized on date form is completed)*** | | | | | | | | | | | |
| **Hospital:** |  | | | | | | | | | **Phone:** |  |
| **Admission Date:** | |  | | | | | **Admitting Diagnosis:** |  | | | |
| **Inpatient Treatments:** | | | |  | | | | | | | |
| **Expected Discharge Date:** | | | | |  | | | **D/C** **To:** |  | | |
|  | | | | | |  | |  |  | | |
| **Other Comments:** | | |  | | | | | | | | |
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| **Dental Benefit *(Complete For All Members))*** |

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| **ALTCS Routine Dental Benefit Used:** | **$** |  |  |

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| **Emergency Dental Benefit Used:** | **$** |  |  |

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| **HCBS Services**  ***(Check all that apply or attach Service Authorizations for details)*** |

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| **Adult Day Health** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Attendant Care** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Home Delivered Meals** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Homemaker** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Personal Care** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Respite** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Other \_\_\_\_\_\_\_\_\_\_\_** | **Provider:** |  | **Phone#:** |  | **Frequency:** |  |
| **Emergency Alert** | **Provider** |  | **Phone#:** |  |  |  |

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| **Home Health Nursing** | **Provider:** |  | | **Frequency:** |  |
| **Phone#:** |  | |
| **Payer Source:** | |  |
| **Home Health Aide** | **Provider:** |  | | **Frequency:** |  |
| **Phone#:** |  | |
| **Payer Source** | |  |
| **Hospice** | **Provider:** |  | | **Frequency:** |  |
| **Phone#:** |  | |
| **Payer Source:** | |  |

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| **Behavioral Health** | | | | | | | | | | | | | | | | |
| **BH Diagnosis:** | | | | |  | | | | | | | | | | | |
| **BH Medications:** | | |  | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | |
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| **BH Services/Providers:** | | | | | | | | | | | | | | | | |
| **Service** | | | | | | | **Provider** | | | **Phone #** | | | | | **Frequency** | |
|  | | | | | | |  | | |  | | | | |  | |
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| **Last Date of Judicial Review:** | | | | | |  | | | **Outcome:** | |  | | | | | |
|  | | | | | |  | | |  | | | |  | |  |  |
|  | **COT** |  | | **Name on Court Order:** | | | |  | | | | **Expiration Date:** | |  | | |

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| **Required Attachments and Other Transitioning Information:** |

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| **Last CM Assessment** | **CM Summary** |
| **Last Quarterly Behavioral Health Consult, if**  **applicable** | **Advanced Directives (Living wills, Powers of Attorney,**  **etc.), if applicable** |
| **List of Medications** | **EPSDT Forms, if applicable** |
| **Contingency Plan, if member receiving critical services** | **Guardian/Conservatorship or Power of Attorney,  if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Out-Pt Adult Physical Therapy Service. The number of visits received for current contract year** | **Lifetime use of Community Transition Service (CTS)** |
| **Respite Hours Utilized** | **Benefit Community Transition Service Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Inpatient Days Utilized** |  |

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|  |  |  |  |  |
| ***Case Manager Name*** |  | ***Phone*** |  | ***Date*** |