Continuity of Care Request Form

Date of Request: _____

What is Continuity of Care?
Continuity of Care is the option for a Medi-Cal beneficiary to continue receiving services for up to twelve months from their existing (current) provider after the beneficiary has moved to another county or has transitioned from a mental health plan to a managed care plan or vice versa. Through Continuity of Care, the beneficiary has the ability to continue receiving services, for a limited period of time, from a provider that has become "out-of-network". Continuity of Care is designed to allow a beneficiary to complete treatment with an existing provider and/or support the smooth transition of services to a new provider.

If you believe you or a beneficiary that you serve are eligible for Continuity of Care, please complete this form and contact LACDMH Quality Assurance Unit at (213) 943-8268 or NetworkAdequacy@dmh.lacounty.gov

Who is making this request?

☐ Beneficiary / Beneficiary's Caregiver ☐ Provider on behalf of Beneficiary

Caregiver's Name (*if applicable*): _____

Beneficiary Information

Beneficiary Name: _____ Date of Birth: _____

Medi-Cal Policy Number (CIN): _____ Start Date of Medi-Cal Coverage: _____

Address: _____

Phone Number: _____ Email: _____

Existing Provider Information

Provider / Agency Name: _____ Contact Name: _____

Address: _____

Contact Phone Number: _____ Email: _____

Clinical Information

Beneficiary's condition/diagnosis (If known): _____

What service(s) is the beneficiary currently receiving with the existing provider? (If known)

_____

Are there any immediate / pressing needs related to the patient's care or risk of harm that needs to be considered?
☐ Yes ☐ No

If yes, please explain: _____

If available, please attach any relevant clinical documentation (e.g., assessment, progress notes, etc.) to this request form

Requestor's signature: _____ Date of signature: _____

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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For LACDMH Quality Assurance Use Only	
☐ Approved Date approved: _____ Date beneficiary was informed of approval: _____ # of sessions approved: _____ Rate determined: _____ Transition plan after Continuity of Care:	☐ Denied Date denied: _____ Date beneficiary was informed of denial: _____ Reason for denial: _____ Attached w/ denial: • A list of in-network SMHS providers • How to access SMHS in LA County • Notice of Adverse Beneficiary Determination – Denial Notice • Handbook and provider directory

DMH Reviewer signature: _____ Date of signature: _____

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health