MH 756
8/26

Los Angeles County Department of Mental Health
Continuity of Care Request Form

Date of Request: _____

What is Continuity of Care?

Continuity of Care is the option for Medi-Cal members to continue receiving services from their existing (current) provider for up to 12 months after the member has moved to another county or has transitioned from a mental health plan to a managed care plan, or vice versa. Continuity of Care is designed to allow members to complete treatment with an existing provider that has become "out-of-network" and/or support the smooth transition of services to a new provider. *For more information on out-of-network providers, please refer to the LACDMH Provider Directory.*

If you believe you or a member that you serve is eligible for Continuity of Care, please complete this form, provide supporting documentation, and submit to LACDMH Quality Assurance Unit at QAPolicy@dmh.lacounty.gov.

To ensure your request is processed without delay, please answer the following questions:

You (or the member you serve) have Medi-Cal with Los Angeles County	☐ Yes	☐ No
You (or the member you serve) meet criteria for Specialty Mental Health Services	☐ Yes	☐ No
You (or the member you serve) have a pre-existing relationship with the existing "out-of-network" provider	☐ Yes	☐ No

For more information on the criteria for Specialty Mental Health Services, please refer to the Member Handbook.

If you answered "No" to **any** of the questions above, please email QAPolicy@dmh.lacounty.gov to troubleshoot your case.

If you answered "Yes" to **all** the questions above, please proceed below.

Who is submitting this request? Please select one of the following:

☐ I am the Medi-Cal member requesting Continuity of Care and authorize my release of information to process this request. The signed Release of Information is attached to this request.

☐ I am the Medi-Cal member's caregiver requesting Continuity of Care on behalf of the member. The signed Caregiver's Authorization Affidavit is attached to this request.

☐ I am the Medi-Cal member's provider requesting Continuity of Care on behalf of the member. The signed Release of Information is attached to this request.

Requestor's Name:	**Requestor's Email:**	**Requestor's Contact Number:**

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Member Information		
Member's Name:	Medi-Cal #:	
Member's Date of Birth:		
Member's Contact Number:	Member's Email:	
Member's Current Address:	City:	Zip code:
Member's Mailing Address (if different from current address):	City:	Zip code:
Member's condition and diagnosis:		

Existing out-of-network Provider Information		
Provider Name:	County:	
Provider Address:	City:	Zip code:
Practitioner's Name:	Practitioner's Contact Number:	
Practitioner's Email:		
Please explain why Continuity of Care is requested for the Medi-Cal Member:		

Please **select one** of the following:

☐ Attached is clinical documentation to support this request (e.g., assessments, progress notes, Release of Information, Caregiver's Affidavit, etc.). Send supporting documentation with this request form through an encrypted email to QAPolicy@dmh.lacounty.gov.

☐ Member records are not available

Requestor's Name:	**Requestor's Signature:**	**Date:**

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FOR LACDMH QUALITY ASSURANCE USE ONLY	
☐ **Approved**	☐ **Denied**
Date approved:	Date denied:
Date member was informed of the approval:	Date member was informed of the denial:
Number of sessions approved: ____ **or** Number of months approved: ____ Continuity of Care is approved from: _____ to _____	Reason for denial:
Rate Agreement ☐ Yes ☐ No	
What is the plan for the client to transition to an in-network provider at the end of the approved time frame?	
Attached Notice of Adverse Beneficiary Determination *(if applicable)* How to access Specialty Mental Health Services: • Behavioral Health Member Handbook: https://dmh.lacounty.gov/our-services/patients-rights/handbooks/ • Provider Directory: https://dmh.lacounty.gov/pd/	

DMH Reviewer's Name:	**DMH Reviewer's Signature:**	**Date:**