

**Nursing Facility Transition / Diversion Wraparound Services:** For individuals who are transitioning from a licensed healthcare facility to a living arrangement in a residential care facility for the elderly or adult residential facilities. Includes wraparound services like assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also includes 24-hour direct care staff on site to meet unpredictable needs in a way that promotes maximum dignity and independence while providing supervision, safety, and security.

**DHCS - CalAIM, Thursday, September 15, 2022**

<b>Provider name:</b>		<b>Care Navigator (LCM) name:</b>	
<b>Contact information:</b>		<b>Member name:</b>	
<b>CIN:</b>	<b>DOB:</b>	<b>AGE:</b>	<b>Has Capacity?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Care plan</b>	
Have I met the goals on my care plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
<b>Physical health</b>	
I can do the following on my own or with the help of a caregiver or support person (check all that apply):	<input type="checkbox"/> Make appointments. <input type="checkbox"/> Track appointments on a calendar. <input type="checkbox"/> Keep appointments or call to reschedule/cancel in advance. <input type="checkbox"/> Know how to call the PCP or Nurse Advice Line. <input type="checkbox"/> Utilize the ER appropriately. <input type="checkbox"/> Know how to attend telehealth appointment. <input type="checkbox"/> Find community resources. <input type="checkbox"/> Call Customer Service to ask questions or request services (change provider request case management). <input type="checkbox"/> Call L.A. Care to schedule rides to appointments, pharmacy, food pantries. <input type="checkbox"/> Understand the <i>Member Bill of Rights</i> . <input type="checkbox"/> Use the <i>Member EOC Handbook</i> .
Do I understand why I take each of my medications and do I take them as instructed by my doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I know when I need to see my care provider? Do I feel comfortable talking to the care provider about what is bothering me and asking questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Can I follow my care team's recommendations (for example, eating right or exercising)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I feel like I can manage my stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):

Do I know how to take care of my health and ask for help when I need it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
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**Mental/emotional health**

I can do the following on my own or with help of a caregiver or support person (check all that apply):	<input type="checkbox"/> Understand my mental health diagnosis and treatment. <input type="checkbox"/> Know where and when to seek care and make informed decisions about care. <input type="checkbox"/> Recognize warning signs related to emotional health/mental health diagnosis. <input type="checkbox"/> Recognize things that upset me and respond in a healthy way. <input type="checkbox"/> Understand why I take my medications and know how to take my medications. <input type="checkbox"/> Identify one or more people I can talk to (for example, support person or group). <input type="checkbox"/> Find help when I need it.
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**Housing**

Do I have safe and stable housing? Do I know how to find help if I need it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I know my rights in my current housing situation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I know how my actions, such as paying rent late, hoarding, and smoking, can affect my housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I understand why I need to maintain my relationship with the landlord?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):

**Daily living**

Can I do things like cook, clean, and shop for myself, or with the help of a caregiver or support person? Can I ask for help when I need it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Can I perform activities of daily living such as bathing, dressing, toileting, transferring, continence, and feeding on my own, or with the help of a caregiver or support person?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I have all the supplies and equipment to live on my own or with the help of a caregiver or support person?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Am I able to get food, transportation, and seek help when I need it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):
Do I have my birth certificate, Social Security card, driver's license, and other records to prove my identity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (describe):

Do I know how to keep track of my money\* and how and where I spend it (for example, rent, bills, and groceries)?

\*Note: intended to be inclusive of all income sources, including CalFresh.

☐ Yes ☐ No  
☐ Other (describe):

#### Provide details for the following

**Required:** Identify any programs or services to which the member was linked during CS-Wraparound. Is the member still receiving services from these programs today?

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**Required:** Describe any ongoing need for care management services related to a specific need or concern.

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**Required:** If member meets criteria to transition to a lower level of care management, identify a program(s) that may be a good fit to continue to serve the member after the end of Wraparound services (if known).

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**Requires Continuing Assistance with ADLs/IADLs** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Dementia Diagnosis:** ☐ Yes ☐ No      **MCI Diagnosis** ☐ Yes ☐ No      **Behaviors?** ☐ Yes ☐ No ☐ Other(describe)

**Wander Risk:** ☐ Yes ☐ No      **Elopement Risk / Exit Seeking** ☐ Yes ☐ No ☐ Other(describe)

**Requires Secure Perimeter** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Requires Continuing Assistance with Medication Mgmt** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Requires 24/7 Caregiving Services** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Requires Meal Preparation Services** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Able to live Independently Alone?** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Will be homeless if Evicted?** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Is there a possibility member would get an ALF waiver and stay at this facility?** ☐ Yes ☐ No ☐ Other(describe)

**Is member willing to apply for an ALF Waiver?** \_\_\_\_\_ ☐ Yes ☐ No ☐ Other(describe)

**Is member willing to apply for reconsideration of SSI income?** ☐ Yes ☐ No ☐ Other(describe)