

Center Name:	Provider # (NPI):
Participant Name:	
Date of Birth (MM/DD/YY):	CIN:
Gender: Male Female Transgender Male Transgender Female	
Managed Care Plan Name:	
Dates of Service: From: _____ To: _____	Planned Days/Week (#_____)
TAR Control Number (TCN):	

(1) TREATMENT AUTHORIZATION REQUEST (TAR) AND ELIGIBILITY

Initial TAR Reauthorization TAR Change TAR

TB Clearance Date (initial TAR only): _____

If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were denied. Yes No N/A

The individual meets all CBAS eligibility and medical necessity criteria and one or more of the following CBAS medical criteria categories as set forth in the current Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020:

Category 1: Nursing Facility Level A (NF-A) or above

Category 2: Organic, acquired or traumatic brain injury and/or chronic mental disorder

Category 3: Alzheimer's disease or other dementias at moderate to severe level

Category 4: Mild cognitive impairment including Alzheimer's disease or other dementias

Category 5: Individuals who have developmental disabilities

(2) DIAGNOSES AND ICD CODES

Diagnosis	ICD Code	Diagnosis	ICD Code
1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	
11.		12.	
13.		14.	

Participant Name:		
Dates of Service: From: _____ To: _____	CIN: _____	

Diagnosis	ICD Code	Diagnosis	ICD Code
15.		16.	
17.		18.	
19.		20.	

(3) MEDICATIONS

No medications or supplements

ACTIVE PRESCRIPTIONS		OVER-THE-COUNTER MEDICATION AND/OR SUPPLEMENTS
1.	2.	
3.	4.	
5.	6.	
7.	8.	1.
9.	10.	2.
11.	12.	3.
13.	14.	4.
15.	16.	5.
17.	18.	6.
19.	20.	7.
21.	22.	8.
23.	24.	9.
25.	26.	10.

Center administers participant's prescribed medication(s)	Yes	No
Participant self-administers prescribed medication(s) at center	Yes	No

(4) ACTIVE PERSONAL MEDICAL/MENTAL HEALTH CARE PROVIDER(S)

NAME	PROVIDER SPECIALTY	ADDRESS	PHONE

Participant Name: _____		
Dates of Service: From: _____ To: _____	CIN: _____	

(5) ADL/IADLs

Independent: able to perform for self with or without device

Needs Supervision: no physical help required but needs to be monitored, even with device

Needs Assistance: physical help or cueing required, even with device

Dependent: unable to do for self, even with physical help, cueing or device

ADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Ambulation				
Bathing				
Dressing				
Self-Feeding				
Toileting				
Transferring				

IADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Accessing Resources				
Hygiene				
Meal Preparation				
Medication Mgmt.				
Money Mgmt.				
Transportation				

(6) CURRENT ASSISTIVE/ADAPTIVE DEVICES

None

Wheelchair

Walker

Gait Belt

Crutches

Hoyer Lift

Cane

Dentures

Glasses or Other Vision Aids

Orthosis/Prothesis

Hearing Device

Augmentative and Alternative Communication (AAC) Device

Specialized Eating Equipment/Utensils

Respiratory Equipment (specify): _____

Other (specify): _____

Participant Name: _____		
Dates of Service: From: _____ To: _____	CIN: _____	

(7) CONTINENCE INFORMATION

Continent

Incontinent of bladder: Occasionally Frequently Always

Incontinent of bowel: Occasionally Frequently Always

External/internal catheter Ostomy

Other (specify): _____

(8) NUTRITIONAL INFORMATION

Body Mass Index (BMI) _____ Underweight Normal Overweight Obese

BMI Not Known Feeding tube Special/therapeutic diet (specify): _____

Difficulty chewing and/or swallowing Needs dietary counseling and education

Other (specify): _____

(9) LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION AND NON-CBAS LONG TERM SUPPORT SERVICES (if known)

LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION

Type of Residence:

Personal Residence (house/apartment)

Community Care Licensed Facility (e.g., Residential Care Facility)

Other Congregate Living

ICF/DD-H

Homeless/Temporary Shelter

Other (specify): _____

Household Composition:

Alone Relative (specify): _____

Non-relative (specify): _____

This space intentionally left blank.

Participant Name: _____		
Dates of Service: From: _____ To: _____	CIN: _____	

SUPPORT SERVICES (IN ADDITION TO CBAS)

Not known _____ None _____

IHSS (In Home Supportive Services) (Number of Hours/Month: _____)

Care Management Program: MSSP _____ Regional Center _____

Other (specify): _____

Veterans Administration Services (specify): _____

Home Delivered Meals _____ Friendly Visitor/Senior Companion/Peer Counselor _____

Telephone Reassurance _____ Transportation _____

Representative Payee _____ Conservatorship _____ Other (specify): _____

(10) OTHER HEALTH SERVICES (if known)

WITHIN THE PAST 6 MONTHS

None _____

Not Known _____

Emergency Department Visit(s)

visits: _____

Explain: _____

Medical Hospitalization(s)

times admitted: _____

Explain: _____

Psychiatric Hospitalization(s)

times admitted: _____

Explain: _____

Nursing Facility

Explain: _____

Home Health Services

Currently receiving _____

Explain: _____

Participant Name: _____		
Dates of Service: From: _____ To: _____	CIN: _____	

OTHER HEALTH SERVICES (if known) Continued

WITHIN THE PAST 6 MONTHS

Hospice Care

Currently receiving

Explain: _____

Mental Health Outpatient Services

Currently receiving

Explain: _____

Other (specify): _____

(11) RISK FACTORS (check all that apply at time of IPC completion)

INTERNAL/CLINICAL RISK FACTORS

None

Mental Illness

High Fall Risk

Substance Use/Abuse

Chronic Pain

Cognitive Impairment

Frailty

Polypharmacy (6+)

Wandering/Exit-Seeking Behavior

Medication Mismanagement

Significant Sensory Impairment

ADL Functional Limitations (3+)

Other (specify): _____

EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH

None

At Risk When Home Alone

Homeless/history of homelessness

Limited or No Social Supports/Family

Financial Insecurity/Poverty/Lack of Resources

Caregiver Stress/Inconsistency

Food Insecurity

IHSS Inconsistency

Lack of Transportation to Medical Visits

Social Isolation/Loneliness

Limited Health Literacy

Emergency Department (ED) visit within 30 days

Language/Communication Barriers

Hospitalization (unplanned) within 60 days

Other (specify): _____

Unstable or Unsafe Housing

Participant Name:		
Dates of Service: From: _____ To: _____	CIN: _____	

(12) NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS
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1.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: NUR SS ACT PT OT SPEECH RD MH	
2.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: NUR SS ACT PT OT SPEECH RD MH	
3.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: NUR SS ACT PT OT SPEECH RD MH	
4.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: NUR SS ACT PT OT SPEECH RD MH	
5.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: NUR SS ACT PT OT SPEECH RD MH	
Additional Information: Use space to include any additional explanations about participant needs/goals/desired outcomes, including the participant's strengths and abilities.	

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

(13) CORE SERVICES

PROFESSIONAL NURSING SERVICES

Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

Treatment(s)/Intervention(s)	Frequency	Goal(s)

2. Need/Problem

Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

PROFESSIONAL NURSING SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
3. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
4. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

PERSONAL CARE SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

SOCIAL SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

SOCIAL SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
3. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
4. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

THERAPEUTIC ACTIVITIES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

THERAPEUTIC ACTIVITIES – PHYSICAL THERAPY MAINTENANCE PROGRAM Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

THERAPEUTIC ACTIVITIES – OCCUPATIONAL THERAPY MAINTENANCE PROGRAM Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

(14) ADDITIONAL SERVICES		
PHYSICAL THERAPY		
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

OCCUPATIONAL THERAPY Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

SPEECH THERAPY Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

REGISTERED DIETICIAN SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

BEHAVIORAL HEALTH SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

TRANSPORTATION SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:

Dates of Service: From: _____ To: _____ CIN:

(15) SIGNIFICANT CHANGES SINCE PREVIOUS IPC (For reauthorization TARs only)

(16) ADDITIONAL INFORMATION (include critical history/information not included in this IPC and relevant to the authorization of this TAR)

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

(17) SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR		
Signatures of the Multidisciplinary Team (MDT) Pursuant to section 14529 of the Welfare and Institutions Code, signing below certifies agreement with the treatments designated in the IPC that are consistent with the signer's scope of practice.		
PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	RN	
	SW	
	AC	
	PT	
	OT	
By signing below I certify that I have reviewed and concur with this IPC.		
PRINTED NAME	SIGNATURE OF THE PRIMARY/PERSONAL HEALTH CARE PROVIDER OR CBAS CENTER PHYSICIAN	DATE OF SIGNATURE
Primary/Personal Health Care Provider CBAS Center Physician		
By signing below, I certify the following: (1) all assessments have been completed and the participant meets all CBAS eligibility and medical necessity criteria as specified in this IPC effective on this date: _____ (NOTE: The TAR will not be approved for CBAS services prior to this date); (2) information contained in this IPC is the result of an MDT person-centered planning process and is documented in the center records; and (3) services scheduled in this IPC will be provided, unless otherwise noted in the health record, after approval of the participant's CBAS eligibility and TAR, and after the participant or authorized representative has signed the CBAS Participation Agreement (Form CDA 7000), no later than the first day of enrollment, consenting to services.		
PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	Program Director	

Privacy Statement: The information requested on this form is required by the Department of Health Care Services, Fee-for-Service or Managed Care Plans, for the purpose of adjudication of TARs for CBAS services. Failure to provide this mandatory information may result in denial of the TAR for CBAS services.

Participant Name:		
Dates of Service: From: _____ To: _____	CIN:	

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES		
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name: _____		
Dates of Service: From: _____ To: _____	CIN: _____	

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name: _____		
Dates of Service: From: _____ To: _____	CIN: _____	

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)