



<b>Center Name:</b>	<b>Provider # (NPI):</b>
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/Prosthesis

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**

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	
<b>Additional Information: Use space to include any additional explanations about participant needs/goals/desired outcomes, including the participant's strengths and abilities.</b>	



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: _____	

<b>TRANSPORTATION SERVICES</b>		
<b>Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____</b>		
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)

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

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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.**

<b>_____ SERVICES</b> <b>Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____</b>		
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.**

<b>_____ SERVICES</b>		
<b>Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____</b>		
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.**

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