Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for LA, Riv, and SB Counties ONLY

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. Individuals are directly responsible for paying their own living expenses.

Send the completed referral via secure fax to: (800) 811-4804.

Eligibility Criteria:
Molina Enrollment: Medi-Cal with Molina
Member must meet one (1) following criteria: Member is being referred for **Nursing Facility Transition** and meets the below criteria: Member has resided 60+ days in a nursing home. Member is willing to live in an assisted living setting as an alternative to a Nursing Facility. Member is able to reside safely in the community with appropriate and cost-effective supports and services **OR** Member is being referred for **Nursing Facility Diversion** and meets the below criteria: Member is interested in remaining in the community. Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services. Member is receiving medically necessary nursing facility LOC or meets the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.
Member consented to Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities referral.

Requestor Information:						
Referrer:	Hospital/SNF	PCP/Clinic	IPA	ECM	Molina CM	Other:
Referrer Organization Name:						
Referrer Name:			Title:			
Referrer Phone Number:			Fax Number:			

Member Information:	
Member Name:	DOB:
Medi-Cal ID:	Preferred Language:
Cell Phone Number:	
Current SNF Name:	
Current SNF Address:	
SNF Contact Name:	Title:
Phone Number:	Fax Number