

Medicaid LTSS Communication Form

Patient's Name:
Medicaid Member ID#: **Date of Birth:** / /
Check one: **Fee for Service** **Managed Care**
If Managed Care: Health Plan Name:
Health Plan Representative:
Phone: **Email:**

Provider Name: **Mailing Address:**

Individuals in HCBS (Waiver or PACE) only: Patient's Residential Address: **Enrollee FIPS Code:**

Provider NPI#: **Provider Representative.:** **Title:**

Telephone: **Fax:** **Date:** / /

Patient Information: DMAS-96 **attached** **unavailable**

Individual admitted to (*check one*): Nursing Facility HCBS services Hospice services on (*date*) / /
from (*check one*): Home Hospital Other Facility:

Level of Care (*NF patients only*): ICF SNF

Patient Pay determination requested

Medicaid Per Diem Rate: \$ RUGS Score (*NF patients only*):

HCBS Provider Hourly Rate: \$

Individual discharged on (*date*) / / to: Home Hospital ALF Other Facility Deceased

Level of care change: from: ICF SNF HCBS Hospice to: ICF SNF HCBS Hospice

Change in income, deductions, health insurance or other (*specify*):

Patient Funds Account balance (*NF patients only*) \$ as of (*date*) / /

Include any additional information here:

LDSS: **FIPS Code:** **Eligibility Worker:**

Telephone: **Fax :** **Date:** / /

Eligibility Information:

Eligible for full Medicaid services beginning / / (*date*) Eligible for QMB Medicaid only

Eligible for Medicare premium payment only

Ineligible for Medicaid Ineligible for Medicaid payment of LTC services from / / to / /

Medicare Part A insurance: Other health insurance: LTC insurance:

Change in deductions, health insurance or other:

To be used only for individuals approved for or receiving long-term services and supports (LTSS): nursing facility (NF) care, home and community based services (HCBS--waiver services or PACE) or Hospice.

PURPOSE OF FORM--To allow the local Department of Social Services (LDSS), Managed Care Organizations (MCOs), nursing facilities, waiver services providers and PACE programs to exchange information regarding:

- The Medicaid eligibility status of an individual;
- A change in the individual's level of care;
- Admission or discharge of an individual to an institution, HCBS, or Hospice, or to report the death of an individual;
- Other information known to the provider that might cause a change in the eligibility status or patient pay amounts. (e.g. planned or incurred medical expense)

USE OF FORM--Initiated by either the LDSS, MCO for individuals in a managed care plan, or the provider of care. A new form must be prepared by the LDSS whenever there is any change in the individual's circumstances that results in a change in eligibility status or information needs to be given to the MCO or provider. The MCO or provider must use the form to document admission date, request Medicaid eligibility status, and notify the LDSS of changes in the individual's circumstances, discharge or death.

NUMBER OF COPIES--Original and one copy for individuals in a NF; original and two copies for individuals in HCBS.

DISTRIBUTION OF COPIES—

- For individuals in a NF, send the original to the MCO (CCC Plus) or the NF (FFS only).
- For individuals in HCBS waiver services, send the original to the following individuals:
 - MCO Care Coordinator (for individuals in a CCC Plus MCO or other managed Medicaid plans)
 - DMAS Case Manager (for FFS individuals with CCC Plus Waiver Tech Assisted services), DMAS, Division of Aging and Disability Services, 600 E. Broad St., Richmond, VA 23219
 - Service Facilitator (for FFS individuals in the CCC Plus Waiver with consumer-directed services),
 - Personal Care Provider (for FFS patients with CCC Plus Waiver personal care services and other services)
 - Case Manager at the Community Service Board for the Community Living and Building Independence Waivers
 - Support Coordinator (Case Manager) at DBHDS for the Family and Individual Supports Waiver
- For individuals in Hospice, including those in a NF or who also receive waiver services, send the original to the MCO (CCC Plus) or to the Hospice provider (FFS).
- For individuals in PACE, send the original to the PACE provider.
- Place a copy of this form in the eligibility case file.

INSTRUCTIONS FOR PREPARATION OF THE FORM--Complete either the Provider/Contractor or LDSS section as appropriate. At the top of the form, enter the Individual's name, date of birth, and Medicaid identification number, if known.

MCO/Provider Section-Complete all data elements in the gray section. Check the appropriate boxes and complete all data elements as appropriate in the white section to the individual's circumstances. A copy of the DMAS-96 must be attached to this form when the individual is first admitted to care.

CCC Plus Care Coordinators and waiver services providers (FFS) must advise the LDSS of the individual's residential address when different from the address from which this form originates and provide the individual FIPS code.

Providers should ensure that the individual understands that they may have a patient pay, which is the amount of their income that must be paid to the provider every month for the cost of long-term care services they receive.

LDSS Section-Complete all data elements of the gray section. Check the appropriate boxes and complete all data elements in the white section as appropriate to the individual's circumstances. Do not provide the source of an individual's income. If the individual is ineligible for Medicaid payment of long-term care due to imposition of a penalty period, send a copy of this form to Eligibility & Enrollment Services Division, DMAS, 600 E. Broad St., Suite 1300, Richmond, Va. 23219.