Agenda

Objective: Improve understanding of Medicaid Assisted Living Processes and Procedures

Audience: ALR Administrators, Business Officers, Case Managers and DHS Social Case Workers

- Overview of Assisted Living and accessing Medicaid LTSS
- Roles and responsibility
- Medicaid LTSS Application, Case Changes and Recertifications
- ALR and Beneficiary Tiers
- RIMFC and SSI Only
- Category D
- Room and Board and Cost of Care
- Billing
- Who to Call if You Have Questions

Accessing LTSS for Assisted Living Residents AND Assisted Living Applicants

RHODE ISLAND

Terms and Acronyms

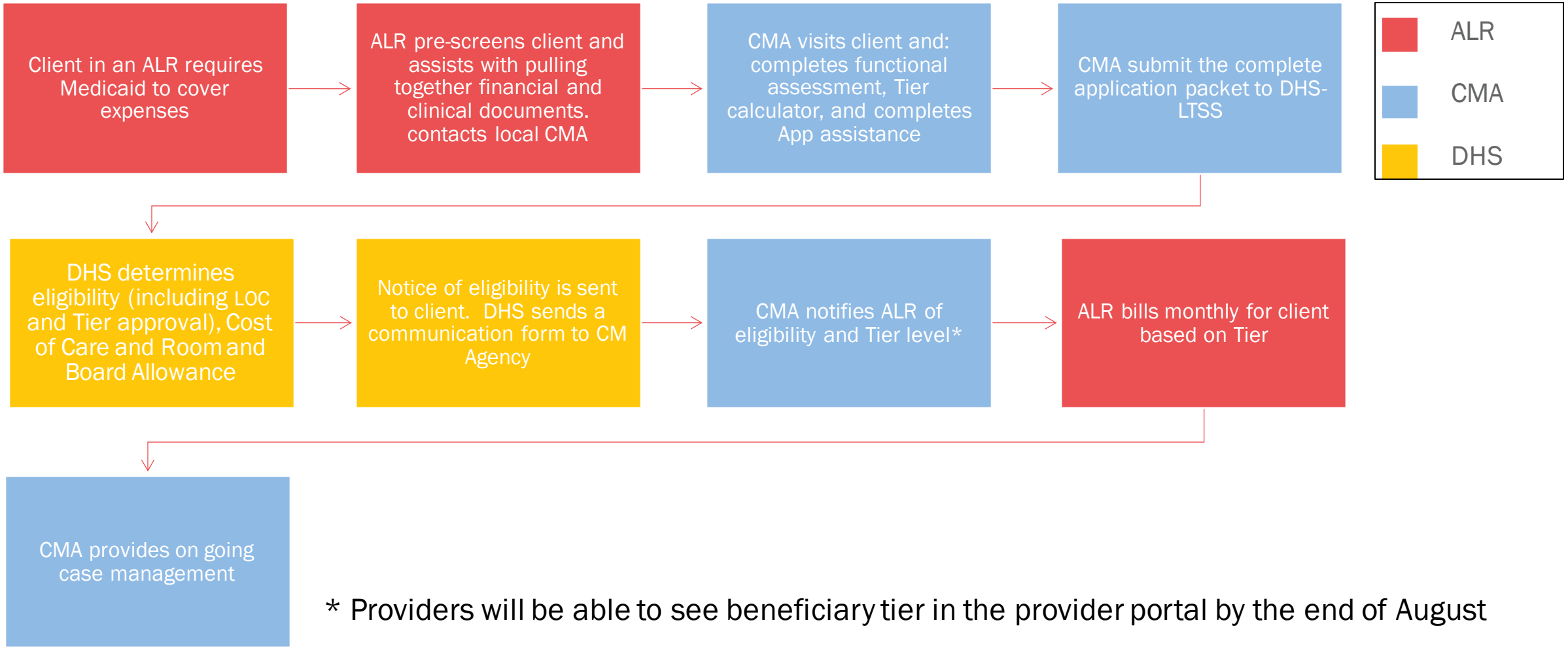
- **ALR - Assisted Living Residence**, or a living arrangement for Elderly and Disabled individuals with clinical and functional needs. Assisted Living Residences (ALR) are publicly, or privately operated residences licensed by the RIDOH. In addition to housing, Assisted Living residents receive assistance with personal care, home care, meals, and other supports to meet residents' changing needs and preferences. (216-RICR-40-10-2).
- **Medicaid Long Term Services and Supports (LTSS)** – A Medicaid eligibility option that provides an array of wrap around services to those who need assistance with activities of daily living
- **CMA** – Case Management Agency (Child and Family Services, East Bay CAP, West Bay CAP, and Tri-County – each serves a specific geographic region)
- **DHS** – Department of Human Services
- **DHS -2** – The application for all public benefits administered through DHS, including Medicaid LTSS
- **FBR** - Federal benefit rate, also known as SSI limit and is the maximum monthly payment to SSI recipients. This figure is adjusted by the Social Security Administration every January
- **OHA** - Office of Healthy Aging
- **PM-1** – The Medical Form currently required to determine level of care. This form must be signed by the client's primary care physician or a Nurse at their primary care office
- **SSP=** State Supplemental Payment. For individuals living in ALRs with income under the FRB, the SSP is $332
- **Tier** - A level of clinical need for a resident and, for an ALR, the level of clinical need they are able to support

Accessing Medicaid LTSS for Assisted Living Care

- Individuals can apply for Medicaid LTSS for Assisted Living either before or after they move into an ALR.
- Regional case management agencies can help individuals apply for Medicaid LTSS
- You can find contact information for your regional case management agency here:

https://oha.ri.gov/what-we-do/access

Medicaid Application and Eligibility Process Overview



* Providers will be able to see beneficiary tier in the provider portal by the end of August

Roles and Responsibilities

RHODE ISLAND

Assisted Living Residence Roles and Responsibilities

ALR

- Screen potential resident during initial intake for potential Medicaid LTSS eligibility
- If income is below $1193.00 apply for Category D eligibility (there is a $20 disregard)
- Complete the Medicaid Assisted Living Referral Form
- Once completed, fax it to the OHA Case Management Agency Supervisor in the assigned catchment area
- Complete the Notification of Admission Form and fax it to the OHA Case Management agency supervisor
- Collect all supporting documents noted on the LTSS Medicaid Application checklist before a resident has been admitted. Provide these documents to the case manager at the initial assessment. (see checklist)
- If the client is eligible for SSI enhancement, a Category D Verification Form should accompany the referral.
- Complete the notification of discharge form as appropriate and fax it to the OHA Case Management Agency

OHA Assisted Living Referral Forms

ALR

INTSTRUCTIONS: IMPORTANT PLEASE READ BEFORE COMPLETING REFERRAL

1. Please use this form to make a referral for a client in need of OHA Assisted Living Wavier Program.

2. Client must be pre-screened for eligiblity and supporting documentation should be collected prior to admission.

3. Reported client must be residing in Rhode Island.

4. Client must be over age 65 or a disabled adult.

5. Please complete all fields when possible and send referral to your regional case management agency within one day of admission. The ALR admission form should accompany this referral.

DATE: **REFFERED BY:**

Name of ALR: **Phone:**

Date of Admission to ALR:

CLIENT INFORMATION

Last Name:	**PROGRAM APPLYING TO:**
First Name/Mid Ini:	OHA Community AL Waiver
Street Address:	
Apt. # / Floor:	Single/Double Room
City/Town:	Client's Primary Care Physician (PCP):

LTSS Checklist

ALR

CMA

MEDICAID: LONG-TERM SERVICES AND SUPPORTS VERIFICATION CHECKLIST

The following list includes documents that you may need for benefit approval. The Department of Human Services may ask for additional documents if needed. Please note: the same document may be used to verify more than one category, for example, a driver's license can verify identity and address.

1. TO VERIFY YOUR IDENTITY, CITIZENSHIP AND/OR IMMIGRATION STATUS

One of the following:

- ☐ Driver's license
- ☐ School or work identification
- ☐ Immigration and Naturalization documents (e.g., Green Card)
- ☐ Birth certificate
- ☐ U.S. Passport
- ☐ Any other documentation requested for citizenship, immigration status, or age may be used for verification of identity

2. TO VERIFY YOUR RHODE ISLAND RESIDENCE

One of the following:

- ☐ Rent or mortgage receipts showing address
- ☐ Library card showing address
- ☐ Voter's registration card
- ☐ Lease agreement of letter from landlord
- ☐ Mail received with your home address (utility bills, bank statements)

LTSS Checklist (Cont.)

ALR

CMA

3. TO VERIFY YOUR AGE

One of the following:

- ☐ Birth certificate
- ☐ Baptismal certificate
- ☐ Adoption records
- ☐ Hospital birth records
- ☐ School records
- ☐ Retirement, Survivors, and Disability Insurance (RSDI) award letter if birth date of child is included
- ☐ Adoption Records
- ☐ Passport
- ☐ Marriage license
- ☐ Driver's license
- ☐ Military service papers
- ☐ Physician's records

4. TO VERIFY YOUR INCOME AND YOUR SPOUSE'S INCOME

All that apply:

- ☐ Check stubs (showing the last 30 days of income)
- ☐ Employer statement showing income before taxes, hourly work schedule and the number of hours worked for the past four weeks (if you get paid in cash or you do not have your check stubs)
- ☐ Social Security, Supplemental Security Income, or Veteran's Benefits award letter
- ☐ Other retirement or disability benefit award letters
- ☐ Proof of alimony received
- ☐ Proof of receipt of unemployment insurance benefits, temporary disability benefits (TDI), Veteran's Administration (VA) benefits.
- ☐ Proof of self-employment income (includes rental income and freelance work): provide tax returns or self-employment ledger
- ☐ Child Support court order

LTSS Checklist (Cont.)

ALR

CMA

5. TO VERIFY YOUR RESOURCES AND YOUR SPOUSE'S RESOURCES

All that apply:

- ☐ Documentation of ownership of a trust
- ☐ Stocks and/or bonds
- ☐ Trust documents, property
- ☐ Proof of ownership of real property other than your home.
- ☐ Annuities- complete annuity contract and any riders
- ☐ Vehicle registration including car, boat, truck, motorcycle, camper
- ☐ Proof of ownership of other income producing property
- ☐ Proof of ownership of a burial plot (if you own more than one)
- ☐ Bank accounts, savings accounts, credit union statements, CD's

6. TO VERIFY YOUR DISABILITY

- ☐ Proof of receipt of Retirement, Survivors, and Disability Insurance (RSDI) or Supplemental Security Income (SSI); copy of the award letter or similar documentation from the Social Security Administration

Case Management Role

CMA

OHA Case Manager will:

- schedule a visit to conduct an initial comprehensive assessment and tier calculator
- at initial assessment, obtain a complete Medicaid application along with supporting documentation from the ALR.
- fax the PM-1 to the client's physician and request it to be completed and sent back to the case manager
- when in receipt of completed PM-1, Mail the completed packed including the UCAT, PM-1, tier calculator, supporting documentation and completed HCBS Communication form
- RI DHS- PO BOX 8709 Cranston, RI 02920

Assessment Best Practices

CMA

- Ensure that detailed information is provided to support the functional (ADLs and IADLs) needs of the customer
- Clearly indicate in comments how medical/clinical diagnoses impact day to day functioning of the customers
- Identified risk to customers resulting from their limitations in the absence of LTSS services
- Provide as much medical supporting documentation as needed to support functional and clinical needs including last visit with primary provider or specialist that the customer sees.
- Make sure the PM1 is complete, and that provider clearly identifies ADL and IADL needs of the customers including behavioral and cognitive needs and limitations when they are complying or not complying with treatment

Case Management Process

CMA

- When case manager is notified by DHS that client is found eligible via DHS communication, documents are created in SAMS Wellsky (OHA database)
- OHA will review work in SAMS and issue an approved service order.
- A plan of care authorization is created in the CSM
- Client received notification directly from DHS regarding eligibility and cost of care

Case Management Process

CMA

- The Notification of Discharge Form (packet) must be completed by the ALR for all waiver recipients and must be faxed to the OHA case manager for all discharges (less than and greater than 30 days)
- The OHA case manger will complete appropriate paperwork to close case if over 30 days.
- The Notification of Discharge form must be completed by the ALR and faxed to the DHS LTSS office for discharges over 30 days.

ALR

Admission and Discharge Forms

Rhode Island Office of Healthy Aging: Notification of Discharge
OHA Community Assisted Living Waiver

This form must be completed and submitted immediately on the date of the patient's discharge. Please send to regional OHA Case Management Agency.

Name and Address of Assisted Living Residence

Name of Resident (last, first, middle initial) *SSN*

Case Manager Name and Phone Number *Contact Person Name and Phone Number*

OHA Assisted Living Waiver

Reason for Discharge: **Date of Discharge:**

Hospitalization:

Name of Hospital

Nursing Facility Admission:

CMA

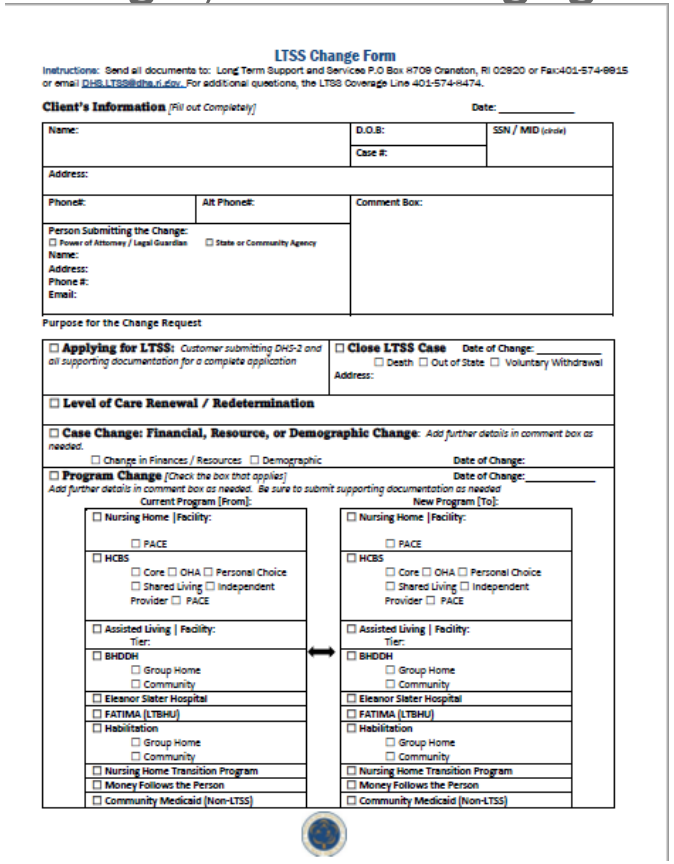
Case Management Process

- The OHA Case Manager will conduct an in-person visit or telephone check in on a monthly basis.
- A reassessment is conducted on an annual basis at which time current financial information is obtained. This will include proof of income and bank statements to verify asset eligibility as well as an updated tier calculator tool.
- The tier calculator will be sent to OCP if it results in any changes in tier level
- If a discharge form is received, Case Manager will need to fill out a program change form for DHS unless discharged due to death
- Client will receive eligibility updates directly from DHS

LTSS Forms: Case Change

CMA

The Change Form should be submitted for customers already active on LTSS when there are additional referrals or status changes, such as changing or entering a facility.



LTSS Change Form

Instructions: Send all documents to: Long Term Support and Services P.O Box 8709 Cranston, RI 02920 or Fax:401-574-8915 or email DHS.LTSS@dhs.ri.gov. For additional questions, the LTSS Coverage Line 401-574-8474.

Client's Information *[Fill out Completely]* Date: _____

Name:	D.O.B:	SSN / MID (circle)
	Case #:	
Address:		
Phone#: / Alt Phone#:		Comment Box:

Person Submitting the Change:
☐ Power of Attorney / Legal Guardian ☐ State or Community Agency
Name:
Address:
Phone #:
Email:

Purpose for the Change Request

☐ **Applying for LTSS:** *Customer submitting DHS-2 and all supporting documentation for a complete application*

☐ **Close LTSS Case** Date of Change: _____
☐ Death ☐ Out of State ☐ Voluntary Withdrawal
Address:

☐ **Level of Care Renewal / Redetermination**

☐ **Case Change: Financial, Resource, or Demographic Change**: *Add further details in comment box as needed.*
☐ Change in Finances / Resources ☐ Demographic Date of Change:

☐ **Program Change** *[Check the box that applies]* Date of Change: _____
Add further details in comment box as needed. Be sure to submit supporting documentation as needed

Current Program [From]:	New Program [To]:
☐ Nursing Home |Facility: ☐ PACE	☐ Nursing Home |Facility: ☐ PACE
☐ HCBS ☐ Core ☐ OHA ☐ Personal Choice ☐ Shared Living ☐ Independent Provider ☐ PACE	☐ HCBS ☐ Core ☐ OHA ☐ Personal Choice ☐ Shared Living ☐ Independent Provider ☐ PACE
☐ Assisted Living | Facility: Tier:	☐ Assisted Living | Facility: Tier:
☐ BHDDH ☐ Group Home ☐ Community	☐ BHDDH ☐ Group Home ☐ Community
☐ Eleanor Slater Hospital	☐ Eleanor Slater Hospital
☐ FATIMA (LTBHU)	☐ FATIMA (LTBHU)
☐ Habilitation ☐ Group Home ☐ Community	☐ Habilitation ☐ Group Home ☐ Community
☐ Nursing Home Transition Program	☐ Nursing Home Transition Program
☐ Money Follows the Person	☐ Money Follows the Person
☐ Community Medicaid (Non-LTSS)	☐ Community Medicaid (Non-LTSS)

- Provide all information about the customer including full name, DOB and SSN
- Indicate person filling out the form and their contact information
- Choose a Purpose for the Change request and check boxes within the selection
- Use the 'comment box' to provide any additional information. Attach verification documents as needed

Note: Submitting a Change form without the needed paperwork ***does not*** *hold a date of application*

Category D

RHODE ISLAND

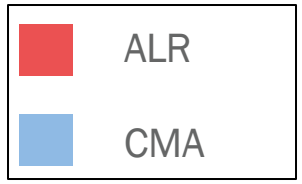
Category D – Increased Payments to Income Eligible Clients

ALR

CMA

- If a determination is made that the individual's gross income is below the threshold set by SSA which is currently $1173 a Category D Assessment form -is completed in full. The form should be signed by either the attending physician, PA, nurse practitioner or the OHA case manager. ALR settings should not be completing this form due to conflict of interest issues but can assist with obtaining assessment from providers.
- The Category D assessment should be completed as soon as possible after identifying a possible eligible resident. It is recommended that the AL start the Cat D application process upon admission, as eligibility is NOT dependent on waiver eligibility. The assessment should be completed in full, with special consideration given to sections on move in date, needs of resident, need for placement, and appropriateness of placement.
- Category D begins on the first of the month following the date of submittal of a complete application, if SSA deems the person financially eligible.
- The completed Category D assessment and Category D Form should be e-mailed to the Office of Community Programs (OCP) via secure e-mail to OHHS.ocp@ohhs.ri.gov

Category D Process (Cont.)



- OCP will review and approve, if appropriate. If the Category D assessment submitted is incomplete or appears to be inappropriate, the application will be returned with requested information and/or reason for denial. Applications that are incomplete will be held and not submitted to SSA until needed information is received.
- OCP submits Category D assessments to the regional SSA office.
- OCP maintains receipt of fax confirmation and approved Category D assessments in file for 1 year.
- Any follow up with SSA is the responsibility of client/representative/family. EOHHS has no communication with SSA after submission.
- SSA office will outreach to the individual requesting the Category D for a telephone interview. Any communication with SSA requires either the resident to be present to give permission for advocacy or *Social Security Administration Release of Information* (Attachment 7). Contact would be with local SSA office covering ALR community.
- If resident moves out the ALR, the ALR is responsible to inform the case management agency of the discharge by completing the *Notification of Discharge* Form (Attachment 6) so that eligibility for Category D can be suspended.

DHS Application Process

RHODE ISLAND

LTSS Application Process

1) Need for LTSS recognized. Customer and Family prepare paperwork for submission

Pre-Application

Complete Application

2) CM will assist to ensure all documentation including assessments are complete and signed

3) Application submitted to DHS.

Note: Any missing documentation will delay the application process

Submission of Application

DHS Receives Application

4) Application and medical documents are checked for signature. Application is date stamped to hold application date

5) Information from application is input into computer system. If more information is needed, an ADR will be sent to address on application

Financial Eligibility

Functional Eligibility

6) Level of Care is determined by the Clinical Team where they review medical documentation received with application

7) Case is authorized by DHS. A notice is mailed to the customer and POA/Auth Rep. A completed HCBS-2 Turnaround is emailed or faxed to CM.

Authorization

DHS has 90 days to process an application for LTSS

Post Eligibility

8) Ongoing case updates should be reported within 10 days and communicated to DHS via DHS Communication/ Change Form

LTSS Application Required Forms

ALR

CMA

Business office staff can check the Health Portal to see if client has Medicaid, however, they should verify with DHS prior to applying.

Client's NOT ACTIVE on Medicaid	Client's ACTIVE on Medicaid	Client's on LTSS and needs a *"program change"*
DHS-2 Application, *fully completed and signed*	Recertification form in lieu of DHS-2, *fully completed and signed*	LTSS Communication form to request a program change
DHS 25, DHS 25M, CP-12 *all fully completed signed and dated*	DHS 25, DHS 25M, CP-12, *all fully completed signed and dated*	DHS 25, DHS 25M, CP-12 *all fully completed signed and dated*
PM-1	PM-1	PM-1
UCAT Assessment	UCAT Assessment	UCAT Assessment
Associated medicals	Associated medicals	Associated medicals
Inquiries can be emailed to: DHS.LTSS@DHS.RI.GOV, mailed to P.O Box 8709 Cranston, RI 02920 or faxed to 401-574-9915		

Ways to Apply for LTSS

There are multiple ways to apply for RI DHS benefits and support, and you can apply for multiple programs simultaneously.

Apply by Mail to: DHS PO Box 8709, Cranston RI
Attn: LTSS

Apply Online: Healthyrhode.ri.gov and the HealthyRhode mobile app

Drop off: Drop boxes are available at 6 field offices throughout RI.

Applying online will allow the client or their Authorized Rep to check their status and access records

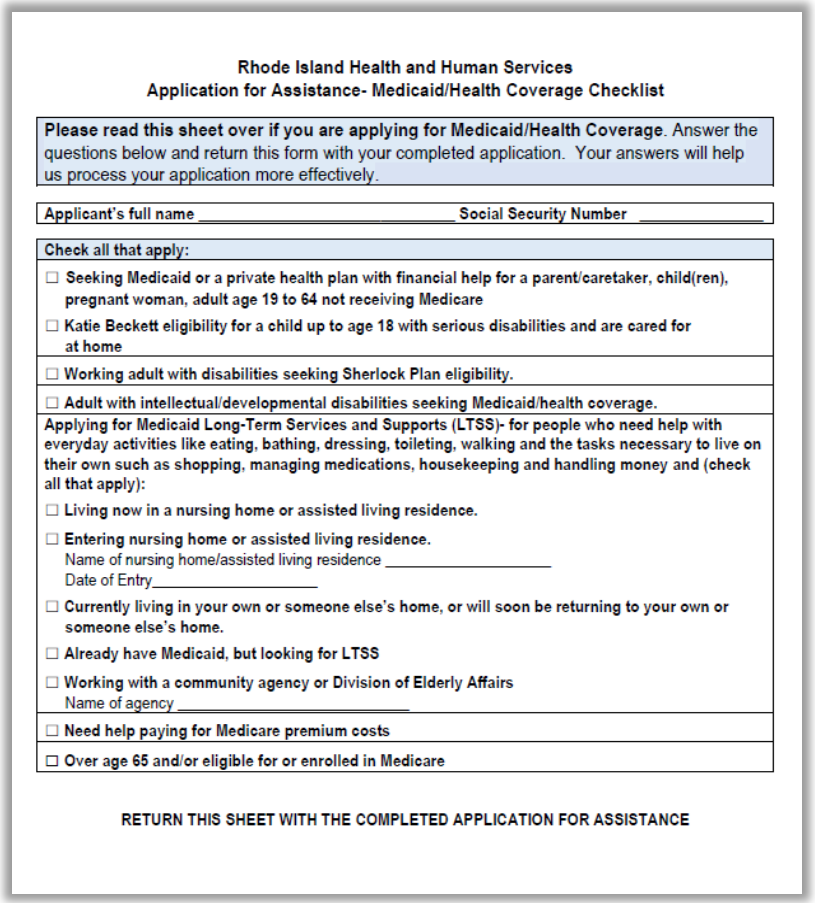
LTSS Forms: Coversheet

ALR

CMA

Coversheets are used to indicate the program that customers are applying for, and it provides LTSS with essential information. Here are some important points to keep in mind.

- An accurate date of birth (DOB) and Social Security Number (SSN) is always needed
- Always check the boxes that apply to the customer
- A coversheet should be submitted with all applications



Rhode Island Health and Human Services
Application for Assistance- Medicaid/Health Coverage Checklist

Please read this sheet over if you are applying for Medicaid/Health Coverage. Answer the questions below and return this form with your completed application. Your answers will help us process your application more effectively.

Applicant's full name _____ Social Security Number _____

Check all that apply:

☐ Seeking Medicaid or a private health plan with financial help for a parent/caretaker, child(ren), pregnant woman, adult age 19 to 64 not receiving Medicare

☐ Katie Beckett eligibility for a child up to age 18 with serious disabilities and are cared for at home

☐ Working adult with disabilities seeking Sherlock Plan eligibility.

☐ Adult with intellectual/developmental disabilities seeking Medicaid/health coverage.

Applying for Medicaid Long-Term Services and Supports (LTSS)- for people who need help with everyday activities like eating, bathing, dressing, toileting, walking and the tasks necessary to live on their own such as shopping, managing medications, housekeeping and handling money and (check all that apply):

☐ Living now in a nursing home or assisted living residence.

☐ Entering nursing home or assisted living residence.
Name of nursing home/assisted living residence _____
Date of Entry_____

☐ Currently living in your own or someone else's home, or will soon be returning to your own or someone else's home.

☐ Already have Medicaid, but looking for LTSS

☐ Working with a community agency or Division of Elderly Affairs
Name of agency _____

☐ Need help paying for Medicare premium costs

☐ Over age 65 and/or eligible for or enrolled in Medicare

RETURN THIS SHEET WITH THE COMPLETED APPLICATION FOR ASSISTANCE

LTSS Forms: DHS-2 Application

ALR

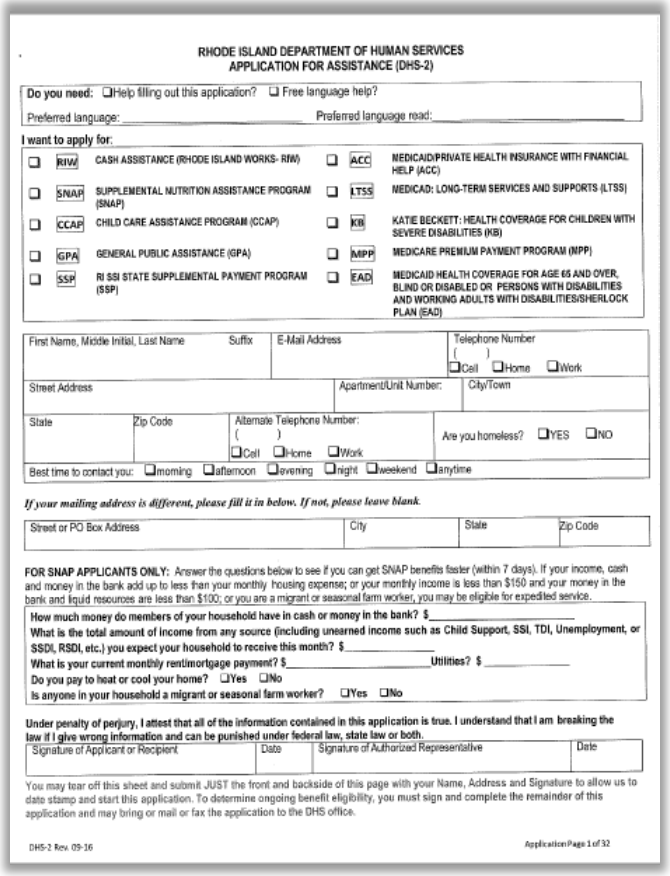
CMA

The DHS-2 is the application or LTSS and should be filled out and signed. Customers should provide all supporting documents as required.

- Specify preferred language for notices
- Make sure to check off LTSS and any other program of choice when applying

Note: a client cannot have Supplemental Nutrition Assistance Program (SNAP) and be in a Nursing home.

- Provide as much information as possible
  - Full name with accurate spelling
  - Best contact number
  - Customers' physical address and include customer's **last known home address** if listing Assisted Living as physical address



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
APPLICATION FOR ASSISTANCE (DHS-2)

Do you need: ❑Help filling out this application? ❑ Free language help?

Preferred language: _____ Preferred language read: _____

I want to apply for:

❑ RIW	CASH ASSISTANCE (RHODE ISLAND WORKS- RIW)	❑ ACC	MEDICAID/PRIVATE HEALTH INSURANCE WITH FINANCIAL HELP (ACC)
❑ SNAP	SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)	❑ LTSS	MEDICAID: LONG-TERM SERVICES AND SUPPORTS (LTSS)
❑ CCAP	CHILD CARE ASSISTANCE PROGRAM (CCAP)	❑ KB	KATIE BECKETT: HEALTH COVERAGE FOR CHILDREN WITH SEVERE DISABILITIES (KB)
❑ GPA	GENERAL PUBLIC ASSISTANCE (GPA)	❑ MPP	MEDICARE PREMIUM PAYMENT PROGRAM (MPP)
❑ SSP	RI SSI STATE SUPPLEMENTAL PAYMENT PROGRAM (SSP)	❑ EAD	MEDICAID HEALTH COVERAGE FOR AGE 65 AND OVER, BLIND OR DISABLED OR PERSONS WITH DISABILITIES AND WORKING ADULTS WITH DISABILITIES/SHERLOCK PLAN (EAD)

First Name, Middle Initial, Last Name / Suffix	E-Mail Address	Telephone Number ( ) ❑Cell ❑Home ❑Work
Street Address	Apartment/Unit Number:	City/Town
State / Zip Code	Alternate Telephone Number: ( ) ❑Cell ❑Home ❑Work	Are you homeless? ❑YES ❑NO

Best time to contact you: ❑morning ❑afternoon ❑evening ❑night ❑weekend ❑anytime

If your mailing address is different, please fill it in below. If not, please leave blank.

Street or PO Box Address	City	State	Zip Code

FOR SNAP APPLICANTS ONLY: Answer the questions below to see if you can get SNAP benefits faster (within 7 days). If your income, cash and money in the bank add up to less than your monthly housing expense; or your monthly income is less than $150 and your money in the bank and liquid resources are less than $100; or you are a migrant or seasonal farm worker, you may be eligible for expedited service.

How much money do members of your household have in cash or money in the bank? $_____
What is the total amount of income from any source (including unearned income such as Child Support, SSI, TDI, Unemployment, or SSDI, RSDI, etc.) you expect your household to receive this month? $_____
What is your current monthly rent/mortgage payment? $_____ Utilities? $ _____
Do you pay to heat or cool your home? ❑Yes ❑No
Is anyone in your household a migrant or seasonal farm worker? ❑Yes ❑No

Under penalty of perjury, I attest that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date

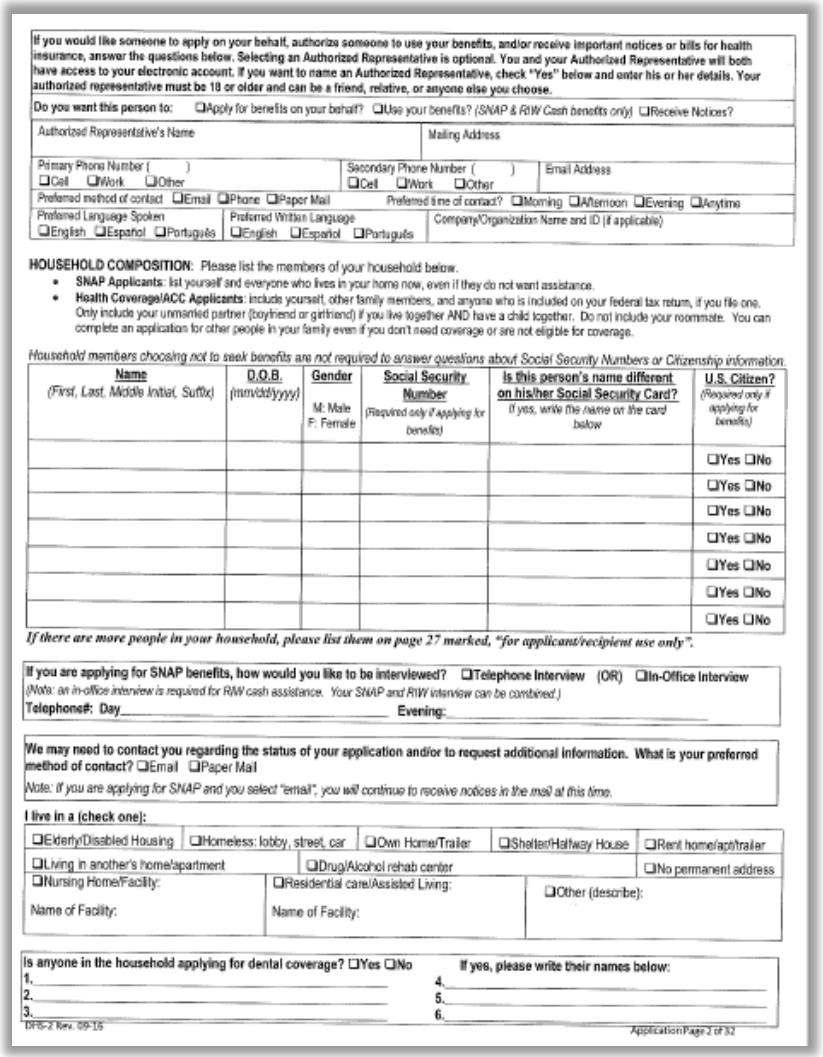
You may tear off this sheet and submit JUST the front and backside of this page with your Name, Address and Signature to allow us to date stamp and start this application. To determine ongoing benefit eligibility, you must sign and complete the remainder of this application and may bring or mail or fax the application to the DHS office.

DHS-2 Rev. 09-16 Application Page 1 of 32

LTSS Forms: DHS-2 Application (Cont.)

ALR

CMA



If you would like someone to apply on your behalf, authorize someone to use your benefits, and/or receive important notices or bills for health insurance, answer the questions below. Selecting an Authorized Representative is optional. You and your Authorized Representative will both have access to your electronic account. If you want to name an Authorized Representative, check "Yes" below and enter his or her details. Your authorized representative must be 18 or older and can be a friend, relative, or anyone else you choose.

Do you want this person to: ☐Apply for benefits on your behalf? ☐Use your benefits? (SNAP & RIW Cash benefits only) ☐Receive Notices?

Authorized Representative's Name | Mailing Address

Primary Phone Number ( ) ☐Cell ☐Work ☐Other | Secondary Phone Number ( ) ☐Cell ☐Work ☐Other | Email Address

Preferred method of contact ☐Email ☐Phone ☐Paper Mail | Preferred time of contact? ☐Morning ☐Afternoon ☐Evening ☐Anytime

Preferred Language Spoken ☐English ☐Español ☐Português | Preferred Written Language ☐English ☐Español ☐Português | Company/Organization Name and ID (if applicable)

HOUSEHOLD COMPOSITION: Please list the members of your household below.

- **SNAP Applicants**: list yourself and everyone who lives in your home now, even if they do not want assistance.
- **Health Coverage/ACC Applicants**: include yourself, other family members, and anyone who is included on your federal tax return, if you file one. Only include your unmarried partner (boyfriend or girlfriend) if you live together AND have a child together. Do not include your roommate. You can complete an application for other people in your family even if you don't need coverage or are not eligible for coverage.

Household members choosing not to seek benefits are not required to answer questions about Social Security Numbers or Citizenship information.

Name (First, Last, Middle Initial, Suffix)	D.O.B. (mm/dd/yyyy)	Gender M: Male F: Female	Social Security Number (Required only if applying for benefits)	Is this person's name different on his/her Social Security Card? If yes, write the name on the card below	U.S. Citizen? (Required only if applying for benefits)
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

If there are more people in your household, please list them on page 27 marked, "for applicant/recipient use only".

If you are applying for SNAP benefits, how would you like to be interviewed? ☐Telephone Interview (OR) ☐In-Office Interview
(Note: an in-office interview is required for RIW cash assistance. Your SNAP and RIW interview can be combined.)
Telephone#: Day_____ Evening:_____

We may need to contact you regarding the status of your application and/or to request additional information. What is your preferred method of contact? ☐Email ☐Paper Mail
Note: If you are applying for SNAP and you select "email", you will continue to receive notices in the mail at this time.

I live in a (check one):

☐Elderly/Disabled Housing | ☐Homeless: lobby, street, car | ☐Own Home/Trailer | ☐Shelter/Halfway House | ☐Rent home/apt/trailer
☐Living in another's home/apartment | ☐Drug/Alcohol rehab center | ☐No permanent address
☐Nursing Home/Facility: Name of Facility: | ☐Residential care/Assisted Living: Name of Facility: | ☐Other (describe):

Is anyone in the household applying for dental coverage? ☐Yes ☐No If yes, please write their names below:
1._____ 2._____ 3._____ 4._____ 5._____ 6._____

DHS-2 Rev. 09-16 Application Page 2 of 32

- Authorized Representative or Power of Attorney information should be provided at the top of Page 2
- Provide all information for the customer and their spouse including:
  - Full name of customer and spouse
  - DOB for customer and spouse
  - SSN for customer and spouse

LTSS Forms: DHS-2 Application (Cont.)

ALR
CMA

All questions marked as 'yes' should be accompanied with verification documents. The customer's signature should be provided on page 32.

All questions that have a LTSS box should be filled out. The questions below are the most important questions to answer:

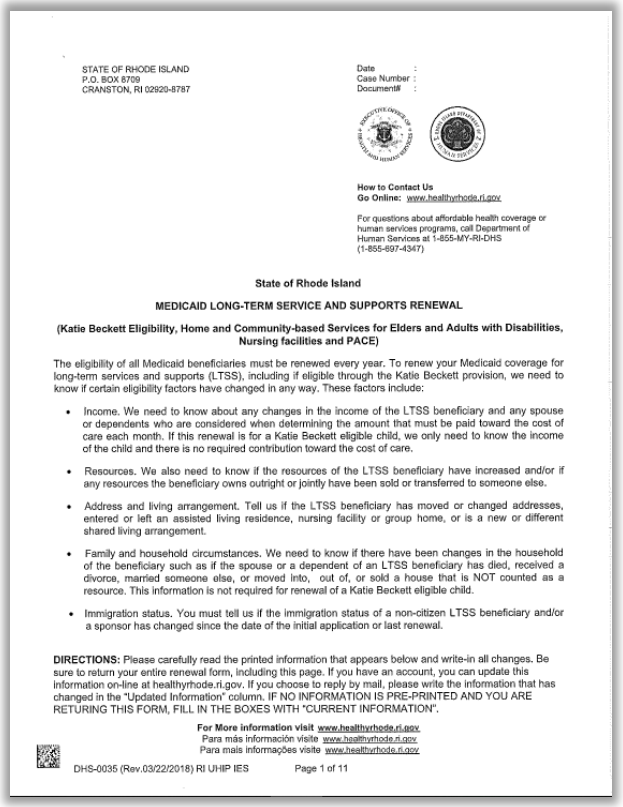
- **Pg. 7 Question 14: Need for LTSS**. There are multiple questions within this section that should be answered
- **Pg. 10 Question 17: Income**. The customer's income including Supplemental Security Income (SSI), Retirement, Survivors, Disability Insurance (RSDI), pensions etc. should be provided. ***(Please note: If income is other than RSDI and SSI, verification is necessary)***
- **Pg. 12 Question 20: Health Insurance:** The customer's insurance information should be listed with policy number and company name
- **Pg. 19-20 Question 31: Resources and Assets**. The customer's resources and assets such as bank accounts, trusts, burial contracts and more are listed here (verification needed for trusts, burial contracts etc. **LTSS does not need 6 months** of bank statements or SAV-91 forms)
- **Pg. 22 Question 39: Expenses**. Such as insurance premiums, medical bills etc. Please also indicate need for retro months here (verification necessary for expenses). Proof of nursing home collecting applied income should also be indicated and provided.
- **Pg. 23 Question 41: Household bills.** The customer's household bills such as rent, mortgage, property taxes etc. should be listed. (verification needed for household bills)
- **Pg. 32: Signature**. The customer must sign and date the application

LTSS Forms: Blank Renewal

ALR

CMA

Blank Renewals can be submitted in lieu of a DHS-2 only if the customer is active on Medicaid and confirmed by DHS. If a renewal is submitted without Medicaid eligibility, a full DHS-2 application will be requested.



STATE OF RHODE ISLAND
P.O. BOX 8709
CRANSTON, RI 02920-8787

Date :
Case Number :
Document# :

How to Contact Us
Go Online: www.healthyrhode.ri.gov

For questions about affordable health coverage or human services programs, call Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347)

State of Rhode Island

MEDICAID LONG-TERM SERVICE AND SUPPORTS RENEWAL

(Katie Beckett Eligibility, Home and Community-based Services for Elders and Adults with Disabilities, Nursing facilities and PACE)

The eligibility of all Medicaid beneficiaries must be renewed every year. To renew your Medicaid coverage for long-term services and supports (LTSS), including if eligible through the Katie Beckett provision, we need to know if certain eligibility factors have changed in any way. These factors include:

- Income. We need to know about any changes in the income of the LTSS beneficiary and any spouse or dependents who are considered when determining the amount that must be paid toward the cost of care each month. If this renewal is for a Katie Beckett eligible child, we only need to know the income of the child and there is no required contribution toward the cost of care.
- Resources. We also need to know if the resources of the LTSS beneficiary have increased and/or if any resources the beneficiary owns outright or jointly have been sold or transferred to someone else.
- Address and living arrangement. Tell us if the LTSS beneficiary has moved or changed addresses, entered or left an assisted living residence, nursing facility or group home, or is a new or different shared living arrangement.
- Family and household circumstances. We need to know if there have been changes in the household of the beneficiary such as if the spouse or a dependent of an LTSS beneficiary has died, received a divorce, married someone else, or moved into, out of, or sold a house that is NOT counted as a resource. This information is not required for renewal of a Katie Beckett eligible child.
- Immigration status. You must tell us if the immigration status of a non-citizen LTSS beneficiary and/or a sponsor has changed since the date of the initial application or last renewal.

DIRECTIONS: Please carefully read the printed information that appears below and write-in all changes. Be sure to return your entire renewal form, including this page. If you have an account, you can update this information on-line at healthyrhode.ri.gov. If you choose to reply by mail, please write the information that has changed in the "Updated Information" column. IF NO INFORMATION IS PRE-PRINTED AND YOU ARE RETURING THIS FORM, FILL IN THE BOXES WITH "CURRENT INFORMATION".

For More information visit www.healthyrhode.ri.gov
Para más información visite www.healthyrhode.ri.gov
Para mais informações visite www.healthyrhode.ri.gov

DHS-0035 (Rev.03/22/2018) RI UHIP IES Page 1 of 11

- Per policy, if a customer is already on Medicaid, we cannot ask the same questions for LTSS eligibility
- The LTSS Renewal allows DHS to ask the LTSS specific questions
  - All boxes should be filled in with customer's complete and current information including:
    - Full name and address
    - Authorized representative information
    - Income, expenses, resources and assets (all questions filled out and verification provided)
    - Signature

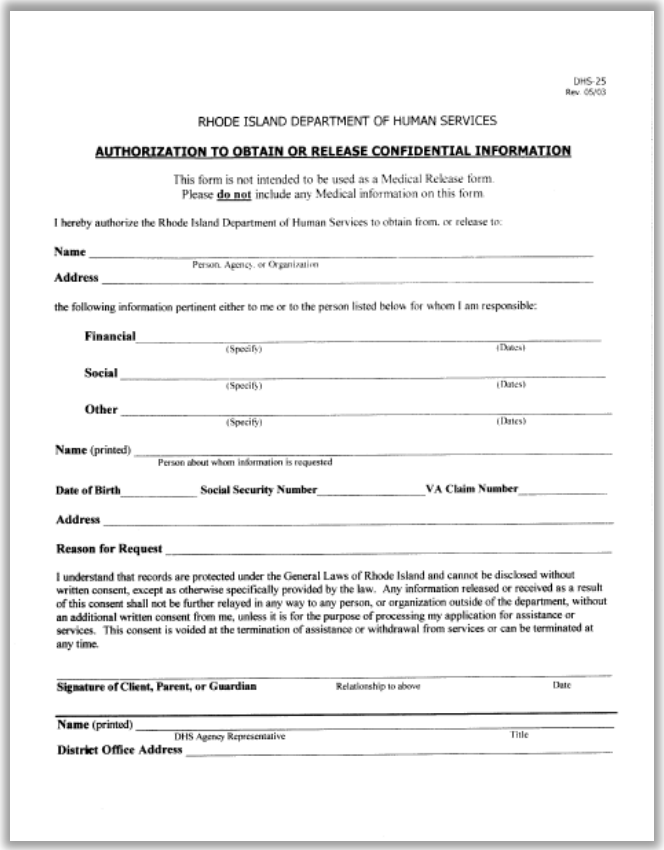
LTSS Forms: DHS 25

ALR

CMA

This form gives access to financial and social information for an individual or entity that has been authorized to review it. Without the DHS 25 form, nursing homes will not receive provider notices and can't obtain information relevant to an LTSS application.

- Customers can authorize a family member, facility, agency or anyone of their choice to obtain and release information for DHS
  - Every individual should have their own release
- Releases are valid for one year
- Customer's information such as full name, DOB, SSN and address must be filled out
- Reason for the request: "Information for LTSS eligibility"
- Customer must sign and date release



DHS-25
Rev. 05/03

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

This form is not intended to be used as a Medical Release form.
Please **do not** include any Medical information on this form.

I hereby authorize the Rhode Island Department of Human Services to obtain from, or release to:

Name _____
Person, Agency, or Organization

Address _____

the following information pertinent either to me or to the person listed below for whom I am responsible:

Financial _____
(Specify) (Dates)

Social _____
(Specify) (Dates)

Other _____
(Specify) (Dates)

Name (printed) _____
Person about whom information is requested

Date of Birth_____ **Social Security Number**_____ **VA Claim Number**_____

Address _____

Reason for Request _____

I understand that records are protected under the General Laws of Rhode Island and cannot be disclosed without written consent, except as otherwise specifically provided by the law. Any information released or received as a result of this consent shall not be further relayed in any way to any person, or organization outside of the department, without an additional written consent from me, unless it is for the purpose of processing my application for assistance or services. This consent is voided at the termination of assistance or withdrawal from services or can be terminated at any time.

_____
Signature of Client, Parent, or Guardian Relationship to above Date

Name (printed) _____
DHS Agency Representative Title

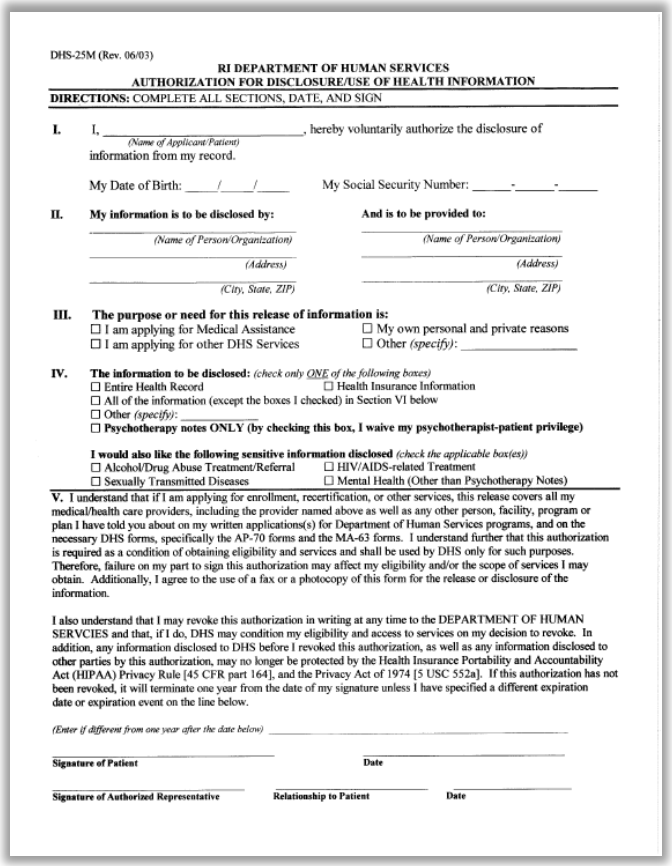
District Office Address _____

LTSS Forms: DHS 25M

ALR

CMA

This form provides access to protected health information to an individual or entity that is authorized to receive and review such information.



DHS-25M (Rev. 06/03)

RI DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of
(Name of Applicant/Patient)
information from my record.

My Date of Birth: ____/____/____ My Social Security Number: _____-_____-_____

II. **My information is to be disclosed by:** **And is to be provided to:**
_____ *(Name of Person/Organization)* _____ *(Name of Person/Organization)*
_____ *(Address)* _____ *(Address)*
_____ *(City, State, ZIP)* _____ *(City, State, ZIP)*

III. **The purpose or need for this release of information is:**
☐ I am applying for Medical Assistance ☐ My own personal and private reasons
☐ I am applying for other DHS Services ☐ Other *(specify)*: _____

IV. **The information to be disclosed:** *(check only ONE of the following boxes)*
☐ Entire Health Record ☐ Health Insurance Information
☐ All of the information (except the boxes I checked) in Section VI below
☐ Other *(specify)*: _____
☐ **Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

I would also like the following sensitive information disclosed *(check the applicable box(es))*
☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

V. I understand that if I am applying for enrollment, recertification, or other services, this release covers all my medical/health care providers, including the provider named above as well as any other person, facility, program or plan I have told you about on my written application(s) for Department of Human Services programs, and on the necessary DHS forms, specifically the AP-70 forms and the MA-63 forms. I understand further that this authorization is required as a condition of obtaining eligibility and services and shall be used by DHS only for such purposes. Therefore, failure on my part to sign this authorization may affect my eligibility and/or the scope of services I may obtain. Additionally, I agree to the use of a fax or a photocopy of this form for the release or disclosure of the information.

I also understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVCIES and that, if I do, DHS may condition my eligibility and access to services on my decision to revoke. In addition, any information disclosed to DHS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

(Enter if different from one year after the date below) _____

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Authorized Representative **Relationship to Patient** **Date**

- A customer can authorize a family member, facility, agency or anyone of their choice to obtain and release medical information for DHS
- Information should be disclosed by: ***Agency information should be listed here***
- Information provided to: ***Department of Human Services, LTSS***
- Sections III and Section IV: Customer should check all that apply
- Customer's signature and date

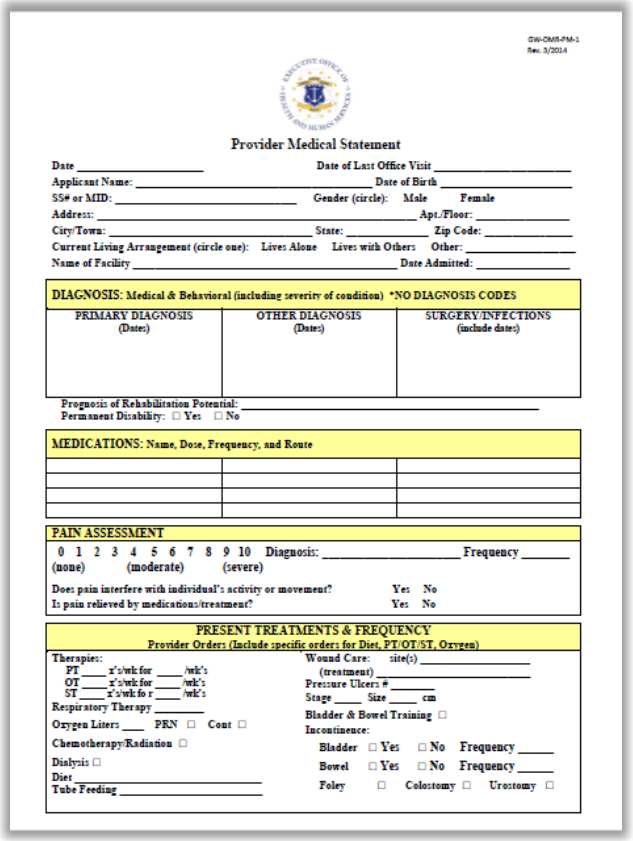
Please note: Signatures are valid for one year

LTSS Forms: PM-1

ALR

CMA

This form must be completed by a licensed health care practitioner with first-hand knowledge of the health status and functional needs of an applicant – serving as a baseline for determining an applicant's level of care.



GW-OMS-PM-1
Rev. 3/2014

Provider Medical Statement

Date _____ Date of Last Office Visit _____
Applicant Name: _____ Date of Birth _____
SS# or MID: _____ Gender (circle): Male Female
Address: _____ Apt./Floor: _____
City/Town: _____ State: _____ Zip Code: _____
Current Living Arrangement (circle one): Lives Alone Lives with Others Other: _____
Name of Facility _____ Date Admitted: _____

DIAGNOSIS: Medical & Behavioral (including severity of condition) *NO DIAGNOSIS CODES

PRIMARY DIAGNOSIS (Dates)	OTHER DIAGNOSIS (Dates)	SURGERY/INFECTIONS (include dates)

Prognosis of Rehabilitation Potential: _____
Permanent Disability: ☐ Yes ☐ No

MEDICATIONS: Name, Dose, Frequency, and Route

PAIN ASSESSMENT

0 1 2 3 4 5 6 7 8 9 10 Diagnosis: _____ Frequency _____
(none) (moderate) (severe)

Does pain interfere with individual's activity or movement? Yes No
Is pain relieved by medications/treatment? Yes No

PRESENT TREATMENTS & FREQUENCY
Provider Orders (Include specific orders for Diet, PT/OT/ST, Oxygen)

Therapies:
PT ____ x's/wk for ____ /wk's
OT ____ x's/wk for ____ /wk's
ST ____ x's/wk fo r ____ /wk's
Respiratory Therapy _____
Oxygen Liters ____ PRN ☐ Cont ☐
Chemotherapy/Radiation ☐
Dialysis ☐
Diet _____
Tube Feeding _____

Wound Care: site(s) _____
(treatment) _____
Pressure Ulcers # _____
Stage ____ Size ____ cm
Bladder & Bowel Training ☐
Incontinence:
Bladder ☐ Yes ☐ No Frequency _____
Bowel ☐ Yes ☐ No Frequency _____
Foley ☐ Colostomy ☐ Urostomy ☐

- All demographic information should be filled out
- Medications should be listed, and attachments sent if necessary
- Questions should be answered using the appropriate codes indicated on the form
- Question: "will the patient be likely to return to the community within 6 months" is marked appropriately so that the customer may receive their Home Maintenance Allowance, ***if applicable***
- A signature is required

Communication Forms between OHA Case Managers and DHS

Communication/ Change Form

HCBS-2 Turnaround Form

RHODE ISLAND

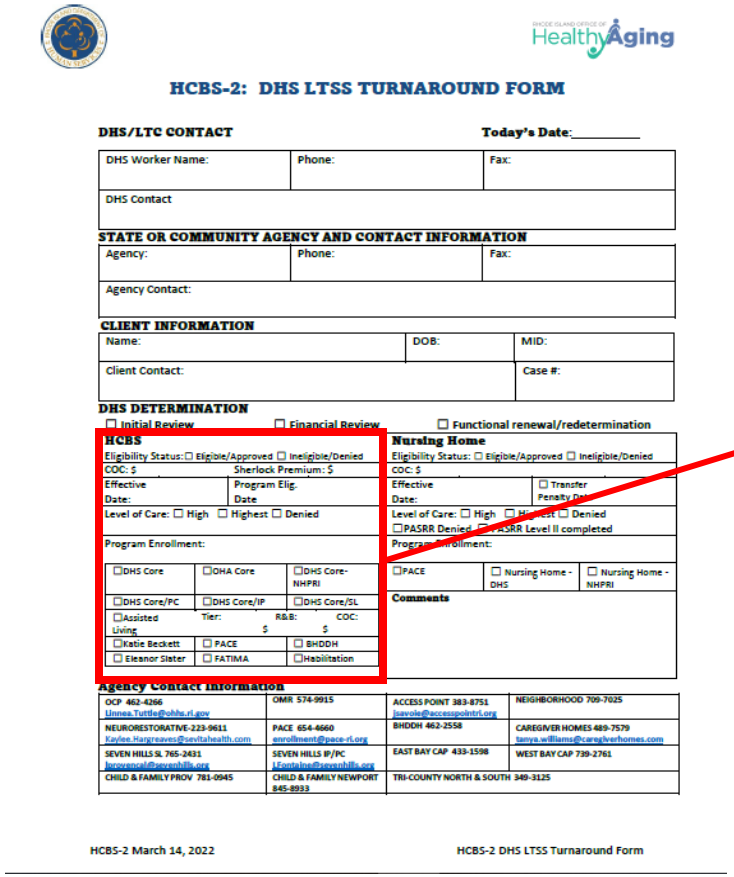
LTSS Forms: HCBS-2 Turnaround Form

DHS

CMA

The Turnaround Form is filled out by DHS LTSS and is sent to the case manager/agency assisting the customer.

Information such as case eligibility, cost of care, Tier Level and more is communicated on this form.



HCBS-2: DHS LTSS TURNAROUND FORM

DHS/LTC CONTACT — Today's Date:_____

DHS Worker Name:	Phone:	Fax:
DHS Contact		

STATE OR COMMUNITY AGENCY AND CONTACT INFORMATION

Agency:	Phone:	Fax:
Agency Contact:		

CLIENT INFORMATION

Name:	DOB:	MID:
Client Contact:		Case #:

DHS DETERMINATION

☐ Initial Review ☐ Financial Review ☐ Functional renewal/redetermination

HCBS

Eligibility Status: ☐ Eligible/Approved ☐ Ineligible/Denied

COC: $ Sherlock Premium: $

Effective Date: Program Elig. Date

Level of Care: ☐ High ☐ Highest ☐ Denied

Program Enrollment:

☐DHS Core	☐OHA Core	☐DHS Core-NHPRI
☐DHS Core/PC	☐DHS Core/IP	☐DHS Core/SL
☐Assisted Living	Tier:	R&B: $ COC: $
☐Katie Beckett	☐ PACE	☐ BHDDH
☐ Eleanor Slater	☐ FATIMA	☐Habilitation

Nursing Home

Eligibility Status: ☐ Eligible/Approved ☐ Ineligible/Denied

COC: $

Effective Date: ☐ Transfer Penalty Date

Level of Care: ☐ High ☐ Highest ☐ Denied

☐PASRR Denied ☐PASRR Level II completed

Program Enrollment:

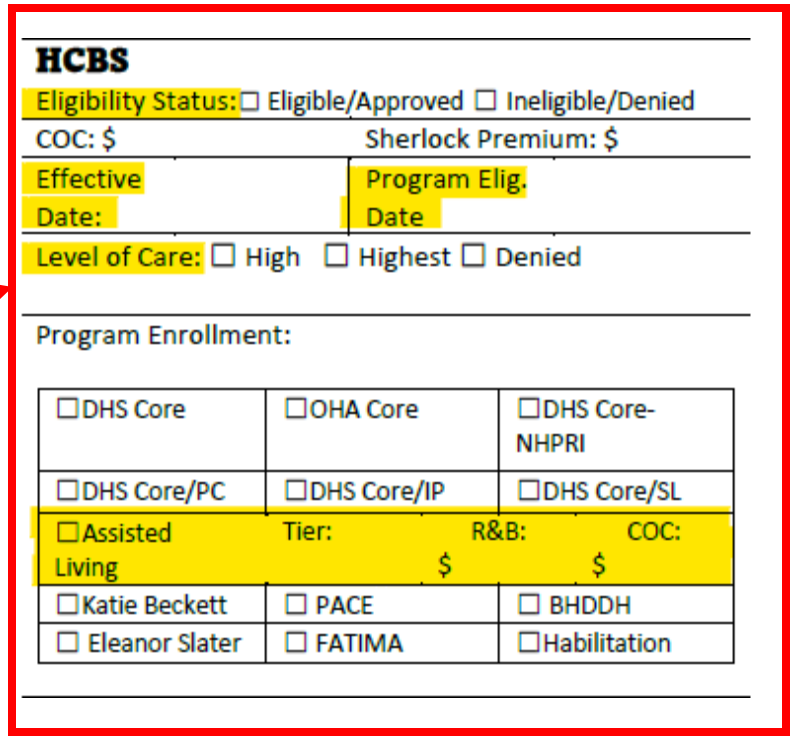
☐PACE	☐ Nursing Home - DHS	☐ Nursing Home - NHPRI

Comments

Agency Contact Information

OCP 462-4266 Linnea.Tuttle@ohhs.ri.gov	OMR 574-9915	ACCESS POINT 383-8751 jsavoie@accesspointri.org	NEIGHBORHOOD 709-7025
NEURORESTORATIVE-223-9611 Kaylee.Hargreaves@sevitahealth.com	PACE 654-4660 enrollment@pace-ri.org	BHDDH 462-2558	CAREGIVER HOMES 489-7579 tanya.williams@caregiverhomes.com
SEVEN HILLS SL 765-2431 hsyoungal@sevenhills.org	SEVEN HILLS IP/PC LFontaine@sevenhills.org	EAST BAY CAP 433-1598	WEST BAY CAP 739-2761
CHILD & FAMILY PROV 781-0945	CHILD & FAMILY NEWPORT 845-8933	TRI-COUNTY NORTH & SOUTH 349-3125	

HCBS-2 March 14, 2022 HCBS-2 DHS LTSS Turnaround Form



HCBS

Eligibility Status: ☐ Eligible/Approved ☐ Ineligible/Denied

COC: $ Sherlock Premium: $

Effective Date: Program Elig. Date

Level of Care: ☐ High ☐ Highest ☐ Denied

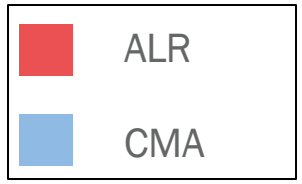
Program Enrollment:

☐DHS Core	☐OHA Core	☐DHS Core-NHPRI
☐DHS Core/PC	☐DHS Core/IP	☐DHS Core/SL
☐Assisted Living	Tier:	R&B: $ COC: $
☐Katie Beckett	☐ PACE	☐ BHDDH
☐ Eleanor Slater	☐ FATIMA	☐Habilitation

Renewals

RHODE ISLAND

LTSS Renewals



****It is critical to make sure DHS has the most up to date mailing information***

- Standard Medicaid Policy requires annual financial AND clinical renewals
- Renewals have been suspended as part of the response to the public health emergency.
- At the end of the public health emergency, Medicaid will return to normal operations, meaning:
  - Clients will be mailed a pre-populated financial renewal form once per year to the address on record
  - Clinical reassessments will be aligned with financial renewals to the extent possible
  - Renewals must be returned with updated information and verification within 30 days
  - Failure to return a renewal will result in a loss of eligibility
    - If the renewal is returned within 30 days of the termination, eligibility can be reinstated

Assisted Living and Beneficiary Tiers

RHODE ISLAND

Provider Certification Standards/Tier A

ALR

- RI Licensure for an ALR in Good Standing
- Compliance with HCBS final rule

  - ✓ Daily assistance with at least 2 ADLs
  - ✓ Personal care and attendant services performed by a CNA. Hours of service must be at least 1 hour per person per week. The hours of the CNA must be adequate to meet the needs as determined by the ALR assessment and person- centered Service Plan.
  - ✓ Housekeeping
  - ✓ Chore services (washing rugs or any heavy maintenance chores)
  - ✓ Companion services
  - ✓ Meal preparation
  - ✓ Medication administration and /or oversight
  - ✓ A program of social and recreational programming that reflects a resident's interests and needs. These activities should promote integration in the ALR and the greater community. The programing may include therapeutic type activities based on the needs of the residents which may include access to, but not limited to, counseling, AA meetings, or activities which focus on maintaining /promoting life skills.
  - ✓ Transportation or coordination of transportation services as specified in the person-centered service plan
  - ✓ Provision of 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides for supervision and safety of the residents.
  - ✓ Minimum of 2 hours of staff orientation and on-going training

Provider Certification Standards/Tier B

ALR

- ✓ All requirements for Tier A AND/ OR

- ✓ Provision of Limited Health Services and/ or an Alzheimer's/ Dementia Special Care Unit as defined in Department of Health Licensing Assisted Living Residences (216-RICR-40-10-2 section 2.5 and 2.6).

OR

- ✓ Proven ability to support additional hours of personal care beyond the Tier A services which may include:
  - ✓ Either extensive assistance with at least 2 ADLs or
  - ✓ 7 hours or more of ADL care as documented in the ALR's assessment and person-centered Service Plan and complex medication management comprising enhanced numbers of meds, more complex delivery of meds, and/ or increased time spent delivering meds.

AND/OR a combination of

- ✓ Ability to support coordination of behavioral and/or dementia care including cuing, redirection, and management of behaviors, for an individual who has been diagnosed with Alzheimer's disease or other related dementia, or a behavioral health diagnosis as determined by a physician.
- ✓ Proven ability to provide support and education to the resident about managing specific health conditions as documented in the resident's person-centered service plan.
- ✓ Demonstrated ability to manage elopement risk or other challenging behaviors that adversely the resident or others.

Provider Certification Standards/Tier C

ALR

- ✓ All Requirements of Tier A and B

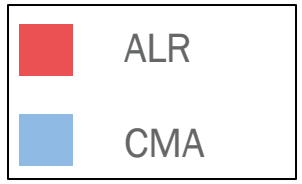
AND

- ✓ Provision of Limited Health Services and/ or an Alzheimer's/ Dementia Special Care Unit as defined in Department of Health Licensing Assisted Living Residences (216-RICR-40-10-2 section 2.5 and 2.6)

AND two of the following:

- ✓ Proven ability to provide Extensive assistance with at least 3 ADLs. And 16 hours or more of ADL care as documented in the ALR's assessment and person-centered Service Plan
- ✓ Single rooms or apartment-like settings
- ✓ Special trained staff such as licensed, certified in BH, dementia, or other specialty area available 24/7.
- ✓ Intermittent skilled care or stabilization services upon transition

Beneficiary Tiers A, B, and C



Tier A	Tier B	Tier C
Assistance with a minimum of two (2) of six ADLs	Extensive assistance with a minimum of two (2) of six ADLs	Extensive assistance with a minimum of three (3) ADLs
AND	OR	AND
At least 1 hour/week of care needed	7 or more hours/week of care needed	16 hours or more per week of care

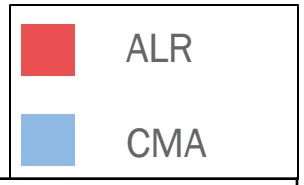
ALR

Payment Determined by Facility Tiers Combined with Client Acuity Tier

- Assisted Livings will need to meet a specific certification standards to determine maximum tier.
- Individuals will be assigned a Resident Tier through the assessment process.

		Facility Licensure and Certification		
		Tier A (Basic)	**Tier B (Enhanced/former Cat F Nov 1. 2021)**	**Tier C (Feb 1, 2022)**
Individual Level of Need	**Tier A Basic**	Tier A ($78)	Tier A ($78)	Tier A ($78)
	Tier B Enhanced (former Cat F)	Tier A ($78)	Tier B ($113)	Tier B ($113)
	Tier C SCU/LHCL	Tier A ($78)	Tier B ($113) with a potential to move to Tier C	Tier C ($136)

Assisted Living Resident Assessment Pathways



New Applicants to Medicaid	Existing Medicaid clients with LOC > 3 Years	Existing Medicaid clients with LOC < 3 Years	NHTP & SNF transition with LOC < 3 Years
• Complete Medicaid Application for LTSS	• Complete a new PM 1	• Complete Assisted Living Tier Calculator	• OCP Completes Assessment
• Include the PM 1	• If the UCAT is older than 1 year, then complete a new one.	• If the UCAT is older than 1 year, then complete a new one.	• OCP Includes the PM1
• Complete the UCAT	• Complete Assisted Living Tier Calculator	• If the UCAT is less than 1 year old, then complete the Enhanced Assessment	• Complete the CMA in place of the UCAT.
• Complete Assisted Living Tier Calculator	• Include the HCBS Communication form	• Include the HCBS Communication form	• OCP Complete Assisted Living Tier Calculator
• If utilizing a Case Management agency, include the HCBS Communication form	• Submit documentation in its entirety to DHS as a Program Change: dhs.ltss@dhs.ri.gov	• Submit documentation in its entirety to OCP: OHHS.ocp@ohhs.ri.gov	• OCP Include the HCBS communication form
• Submit documentation in its entirety to: State of Rhode Island Department of Human Services (DHS) P.O. Box 8709, Cranston, RI, 02920	• DHS will return the HCBS communication form to the Case Management Agency • DHS will record Tier change on internal spreadsheet	• DHS will return the HCBS communication form to the Case Management Agency • DHS will record Tier change on internal spreadsheet	• OCP submits documentation in its entirety to: • Department of Human Services (DHS) • OCP will return the HCBS communication form to the Case Management Agency and record Tier change on internal spreadsheet
• DHS will return the HCBS communication form to the Case Management Agency			

AL Beneficiary Tier Calculator:
Tier B example
(based on hours)

- Individual needs assistance with 4 ADLs – 2 at moderate level of assistance and 2 at minimum level of assistance
- Functional impairment adjustment IS approved
- Therefore the individual is assigned to Tier B due to requiring more than 7 hours/week for ADLs

Tier A	Tier B
Assistance with a minimum of two (2) of six ADLs	Extensive assistance with a minimum of two (2) of six ADLs
AND	OR
At least 1 hour/week of care needed	7 or more hours/week of care needed

INDIVIDUAL'S NAME:		DATE:	
SOCIAL WORKER/CASE MANAGER:		Signature:	

ALR
CMA

Please fill in the orange highlighted cells in the calculator, then see below in row 41 for resulting Assisted Living Tier eligibility.

Please fill in the times per day and days per week the individual requires assistance with each ADL listed below and insert an 'x' in the level of assistance needed for each ADL.

	Ambulation	Transfers	Bathing	Dressing	Eating	Toileting	Totals
Minutes Allowed*	15	15	30	15	30	30	
Times per day	1	2	1	1	1	1	
Days per week	4	7	3	7	4	7	
Level of Assistance							
0 = Independent			x	x			
1 = Minimum / Supervision					x	x	
2 = Moderate / Limited Assist	x	x					
3 = Maximum / Extensive Assistance							
4 = Total / Total Dependence							
Total Minutes Per Week	45.00	157.50	-	-	30.00	52.50	285.00
Total Hours per week	0.75	2.63	-	-	0.50	0.88	4.75

* **Minutes Allowed:** The numbers represented are maximum mintues allowed per task (allowable minute

Functional Impairment Calculator

If the individual has any functional impairment listed below, select Y in the cell below.

Functional Impairments approved? (Y/N	Y

This calculation is made to represent those functional limitations that add substantial time necessary to complete the task (beyond the level of assistance noted above). Individuals must have a documented diagnosis and supporting documentation outlining how the individual's functional impairment significantly impacts their ability to perform the tasks outlined above. **Examples of qualifying functional impairments include:**

- Behavioral Issues, Limited Range of Motion, Spasticity/Muscle Tone, Fine Motor Deficit, Cognitive Impairment, Decreased Endurance, Pain, Open Wound, Complex Medication Management, Ostomy Care, Urinary Catheter Care, Pressure Ulcer Treatment

Functional Impairment Calculator	2	2	1.5	1.33	2	2	
Total Minutes Per Week	90.00	315.00	-	-	60.00	105.00	570.00
Total Hours per week	1.50	5.25	-	-	1.00	1.75	9.50

Assisted Living Tier Assignment	
# ADLs w/ any assistance needed	4
# ADLs w/ extensive/total assist neede	0
Total Hours/week Approved	9.50
Assisted Living Tier Assignment	**Tier B**

Tier A requires at least 1 hour/week **AND** 2 ADLs w/any assistance
Tier B requires at least 7 hours/wk **OR** 2 ADLs w/extensive assistance

APPROVAL:	**Signature**			**Date**	
PLEASE TYPE:	**Name:**		**Title:**	**Office:**	

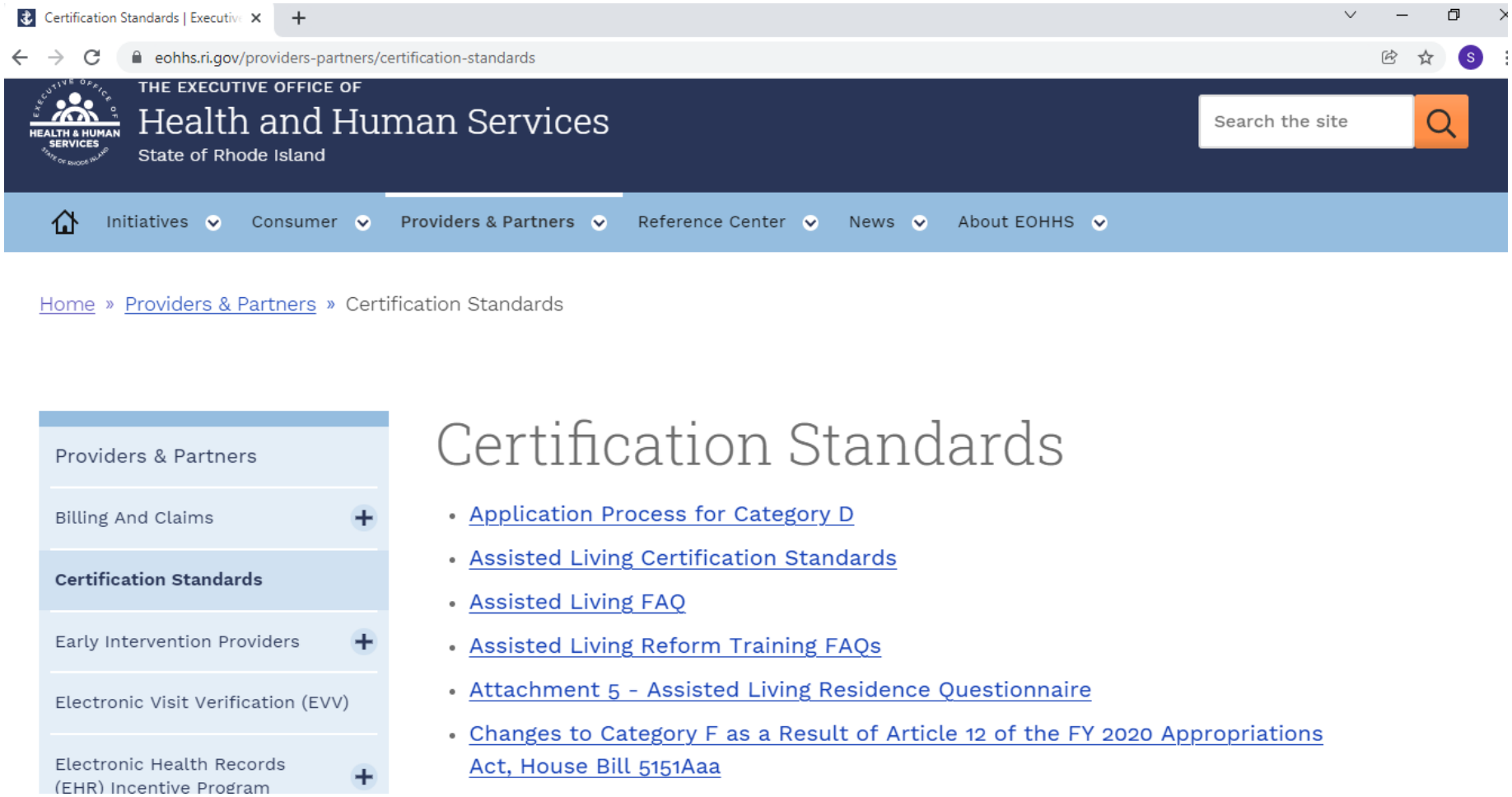
RHODE ISLAND

Appendix

ALR

http://eohhs.ri.gov/provders-partners/certification-standards

The EOHHS website contains the most current information on Assisted Living Payment Reform

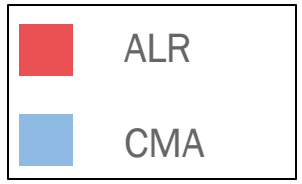


RHODE ISLAND

RIHMFC

RHODE ISLAND

RIHMFC and SSI Only



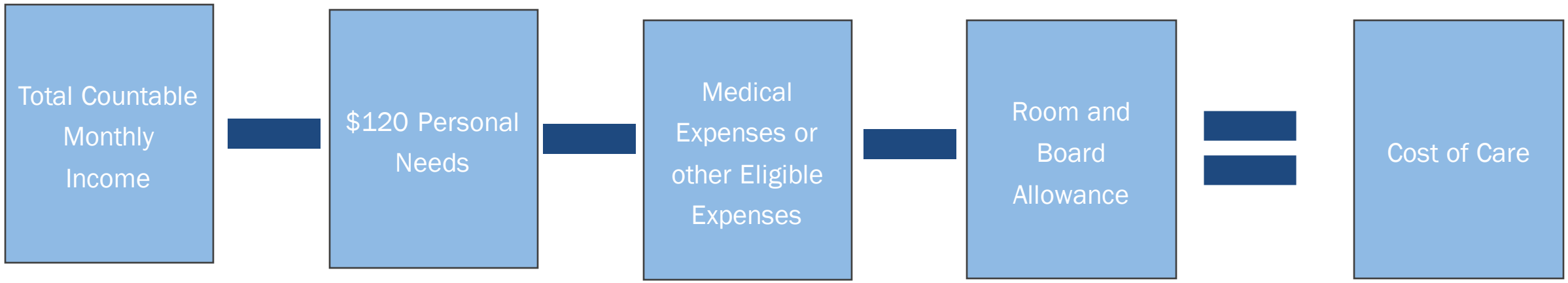
- RIHMFC refers to a separate waiver once held by the state which allowed direct state payments to 4 ALRs that provided single room residences to low-income Rhode Islanders
- Since all rates have been adjusted and the room and board allowance takes single vs. double rooms into account, the RIHMFC designation is no longer relevant
- ALRs may admit individuals who do not meet LTSS level of care standards.
- ALRs with individuals on SSI but not LTSS qualify for a state supplemental of $206 / individual/ months paid from DHS
- ALRs may qualify for this payment even if they are not enrolled as Medicaid Providers

Room and Board and Cost of Care

Cost of Care Calculation

ALR
CMA
DHS

ALR Room and Board and Cost of Care Allowance is described in 210-RICR-50-00-8.6



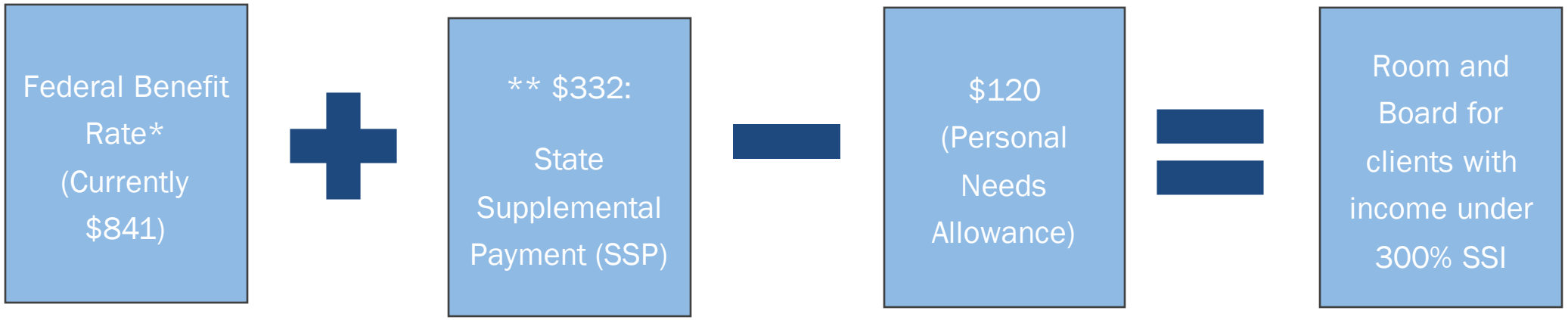
ALR consumers must pay BOTH Room and Board AND their Cost of Care (if any) to the ALR each month

Room and Board Allowance – under Medicaid income limit

ALR Room and Board and Cost of Care Allowance is described in 210-RICR-50-00-8.6

Clients with incomes under 300% of the Federal Benefit Rate will not have a cost of care

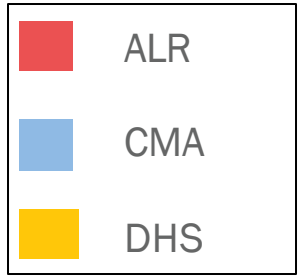
ALR
CMA
DHS



* Federal Benefit Rate changes every January

**Any ALR resident with income under the FBR should apply for Cat D to get the SSP

Room and Board Allowance – above Medicaid income limit



ALR Room and Board and Cost of Care Allowance is described in 210-RICR-50-00-8.6

For individuals with incomes above the Medicaid limit, single vs. double room matters!

Single individual with single room: 300% FBR - $120

Single individual with double room: (85% of 300% FBR) - $120

Married individual, single room: 300% FBR - Spousal Allowance - $120

Married individual, double room: (85% of 300% FBR) - Spousal Allowance - $120

Billing Best Practices

Billing Best Practices

ALR

- Billed electronically as an 837 Professional Waiver or the paper Waiver claim form
- Billed as a per diem
- Procedure Code T2031
- Diagnosis should be the clinical diagnosis from the physician or providers can use Z742 – Need for assistance at home and no other household member able to render care
- Reimbursement for Tier A is $78.00 per day effective 11/1/2021.
  - $69.00 per day effective 10/1/2018 – 10/31/2021
  - Previous to 10/1/18 the rate was $42.16
- Effective 11/1/2021, recipients in Tier B, can be billed with the UB modifier for a reimbursement rate of $113.00 per day
- Effective 2/1/2022, certified Tier C providers can bill with UC modifier for a reimbursement rate of $136.00 per day.
- Billing is done monthly with the units representing the numbers of days the client attended
- Clients must be on the DEA Assisted Living Waiver to be eligible

Checking Eligibility, Cost of Care and Tier

ALR

CMA

Example of Medicaid Recipient Eligible for Assisted Living Services in LTSS

Contact Us | Logout

Rhode Island Executive Office of Health and Human Services

Medicaid

My Home | Eligibility | Claims | Files Exchange

Eligibility > Verify Eligibility Response

Friday 05/06/2016 03:16 PM EST

Eligibility Verification Response

Back to Eligibility Verification Request

Expand All | Collapse All

Verification Response ID 201612706386

Recipient Information

Recipient ID	035269839	**Recipient Name**	MARY LOU SCHLIP
Birth Date	06/22/1938	**Gender**	Female
Date Of Death	_		

Benefit Plan Details

Plan Name	Effective From Date	Effective To Date	Base Deductible	Message
Categorically Needy Services	04/20/2016	05/06/2016	$0.00	Limitations apply to Vision and Dental services
RI Housing Assisted Living	04/20/2016	05/06/2016	$0.00	Recipient may be subject to cost for patient share

Service Type Code Details - Covered

Medicare Details

Demographic Details

R4.2.70

Who to Call When You Have Questions

Office of Healthy Aging- Case Management Agencies

	Agency Information	Contact Information	Areas Covered
1	**Child & Family Services** 31 John Clarke Road Middletown, RI 02842 848-4185	Supervisor: Annie Stoehr astoehr@childandfamilyri.org phone: 848-4145 fax: 841-8841	Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton **Director: Jodi Eyre 848-4120** jeyre@childandfamilyri.org
2	**Child & Family Services** 1268 Eddy Street Providence, RI 02905	Supervisor: Jennifer Allen jallen@childandfamilyri.org phone: 780-2248 fax: 781-0945	Providence **Director: Jodi Eyre 848-4120** jeyre@childandfamilyri.org
3	**East Bay CAP** 100 Bullocks Point Avenue East Providence, RI 02915 437-1000	Supervisor: Robin Covington rcovington@ebcap.org phone: 490-1152 fax: 433-1598	Barrington, Bristol, Central Falls, East Providence, Pawtucket, Warren
4	**Tri-County** 1935 Kintstown Road Wakefield, RI 02879 789-3016	Supervisor: Regina Spirito rspirito@tricountyri.org phone: 709-2643 fax: 284-4546	Block Island, Charlestown, Exeter, Hopkinton, Narragansett, North Kingstown, Richmond, South Kingstown, Westerly
5	**Tri-County** 1126 Hartford Avenue Johnston, RI 02919	Supervisor: Regina Spirito rspirito@tricountyri.org phone: 709-2643 fax: 349-3125	Burrillville, Cranston, Cumberland, Foster, Glocester, Johnston, Lincoln, North Providence, North Smithfield, Scituate, Smithfield, Woonsocket
6	**West Bay CAP** 487 Jefferson Blvd. Warwick, RI 0286 732-4660	Supervisor: Briana Bishop bbishop@westbaycap.org phone: 921-5145 fax: 739-2761	Coventry, East Greenwich, Warwick, West Warwick, West Greenwich **Director: Kelly McHugh** Phone: 384-7781 kmchugh@westbaycap.org Fax:739-2761

DHS Customer Service

DHS Coverage Line

- LTSS specialists can be reached between 8:30 a.m. and 3 p.m. Monday- Friday, except holidays, at (401) 574-8474 or 1-855-MY-RIDHS (1-855-697-4347).
- If your issue cannot be immediately resolved, the specialist will flag it to be worked

LTSS Email: DHS.LTSS@dhs.ri.gov

- Email is checked and triaged daily
- If you have more than one case to check on, email is best
- Applications **cannot** be submitted to this email address

DHS LTSS Mailing Address:

Long Term Support and Services P.O Box 8709 Cranston, RI 02920.

LTSS Contact Directory

Unit	Description	Contact	Email	Phone
LTSS Coverage Line and Case Maintenance	Status update on all LTSS cases including applications, change requests, appeals and general questions		DHS.LTSS@dhs.ri.gov	401-574-8474
New Applications	Initial intake on all LTSS applications including evaluation for community Medicaid while LTSS is pending, sending requests for additional documentation, and completing less financially complex cases.	Nicholas James Darlene Altieri	Nicholas.James@dhs.ri.gov Darlene.Altieri@dhs.ri.gov	401-259-6311 401-598-6906
Financial Level II	More financially complex applications including those with transfer penalties, community spouses and resource reductions	Joy Thibodeau Moore	Joy.thibodeaumoore@dhs.ri.gov	401-712-3707
HCBS and Program Changes	All initial HCBS cases that require DHS home visit. LTSS Case changing from one program type to another	Kerry Cook	Kerry.cook@dhs.ri.gov	401-302-3721
Expedited HCBS Eligibility Policy	Requests for expedited HCBS eligibility policy including urgent HCBS, Eleanor Slater discharges and hospital discharges to the community.			
Ongoing HCBS Support	Provider Escalations and ongoing client support services including the need to increase hours, agency changes, prior authorization issues			

Rose Leandre, Administrator: Rose.Leandre@dhs.ri.gov, 401-574-8093
Ramona Rodriguez, Assistant Administrator: Ramona.Rodriguez@dhs.ri.gov 401-574-8311
Brianna King, Chief Implementation Aide: Brianna.king@dhs.ri.gov; 401-574-8068
Rebecca Cahoon, Chief Clerk: Rebecca.Cahoon@dhs.ri.gov, 401-477-9167

EOHHS Escalation Team

- Case escalations should first be reported to DHS as a first point of contact for issues and questions
  - Providers can call or email (sending via secure email) cases to the following:
  - DHS contact: Help line - 401-574-8474 dhs.ltss@dhs.ri.gov
- Case escalations with issues **dating back more than a year** should be sent to the LTSS Escalation Team
- When sending cases to the Executive Office of Health and Human Services (EOHHS), please be sure to use the communication tool (excel file) and send to EOHHS by emailing OHHS.LTSSEscalation@ohhs.ri.gov
  - EOHHS Contacts: OHHS.LTSSEscalation@ohhs.ri.gov ; Sally.mcgrath@ohhs.ri.gov
- Case escalations for questions related to RAs can be sent to Gainwell Technologies (Formerly DXC)
  - Gainwell provider contact: Karen Murphy - Customer Service help desk 401-784-8100