OUTLINE

1. Policies and procedures review
   A. Timeliness
   B. Application submission
   C. Review of requirements for a complete application and program changes

2. Slips

3. Billing

4. Appendix
POLICIES AND PROCEDURES FOR SLIPS AND BILLING
REVIEW OF POLICIES AND PROCEDURES

- **Timeliness**
  - Claims must be submitted within 1 year of the service date in order to be paid by the state
  - Claims are defined as an attempt to bill MMIS
  - Additional details regarding timely filing can be found at the following link
    [http://www.eohhs.ri.gov/ProvidersPartners/Billingamp;Claims/ClaimsProcessing.aspx](http://www.eohhs.ri.gov/ProvidersPartners/Billingamp;Claims/ClaimsProcessing.aspx)

- **Other timeliness considerations**
  - For initial LTSS eligibility – Starting in the Summer of 2021, we will be notifying each facility on a monthly basis about any admit slips with service dates that have been entered for new applicants, are approaching 90 days old and for whom we do not have the required paperwork for eligibility. These slips will be moved to ‘not necessary’ after 100 days with no corresponding applications.
**COMPLETE APPLICATION – INITIAL APPLICATION REQUIREMENTS**

- Cover sheet
- Application for Assistance (DHS-2)
- Medical Evaluation of Applicant for Level of Care (PM-1)
- SCW Evaluation of Care (AP-70.1)
- ID Screening form MI and DD (MA-PAS-1)
- Authorization to Obtain or Release Confidential Information (DHS – 25)
- Authorization for Disclosure/Use of Health Information (DHS – 25M)
- Home and Community Based Waiver-Notification of Choice (CP – 12)

*All of these documents can be found at the following link:*
http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidLTSSApplication.aspx

*See Grid in appendix section for additional details*
PROGRAM CHANGES REQUIREMENTS

- Change Form (should be entered anytime there are changing financials or changing location)
- CP – 12
- DHS – 25 – if not already on file for this facility and timeframe
- DHS – 25M – if not already on file for this facility and timeframe

All of these documents can be found at the following link:
http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidLTSSApplication.aspx

*See Grid in appendix section for additional details
BEST PRACTICES

- In addition to the complete application package noted above, an admission slip is also required in order to clearly identify the segment being billed.
- Entering the slip in conjunction with submitting the complete application will lead to a more streamlined eligibility/billing decision and subsequent payment.
WHY DO WE NEED TO ENTER SLIPS

- Admit and Discharge slips are required to create a record the duration of institutional LTSS care being provided. While the slips are a critical part of determining payment for a facility, there are additional details required to determine whether payment should be made.
- Slips should only be entered where the facility expects to receive Medicaid payment.
- Entering a slip for a service does not take the place of billing the state. Rather, the slip entry is used to validate that the claim received matches the segment identified by the slip.
- Similarly, entering a slip for a new admission does not take the place of needing to provide all of the required documents to be considered a complete application.
TYPES OF SLIPS

There are 2 different slip types that nursing homes should enter and selecting the particular type will depend on the type of service you are planning to submit a claim for.

The three types of slips are:

- Admission
- Discharge

A note about the Long Term Care Referral form available on CSM:

- Used to be used for indicating that a nursing home is planning to submit an application for a new patient but is no longer necessary. Instead, please utilize the following link to access the DHS-2 where an application can be completed. The Long Term Care Referral forms are not consistently reviewed so the process will be more streamlined by filling out the DHS-2 and providing any corresponding required documents.

http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidLTSSApplication.aspx
ADMISSION SLIPS

When to enter

1. Applying for the first time for NH care
2. With continuing or pending LTSS if:
   1. If moving directly from another facility - no new application needed

When not to enter

1. Not guaranteed they will be applying for LTSS
2. Patient is private pay
3. On managed care MCO and stay is less than 30 days
DISCHARGE SLIPS

When to enter

1. Discharge to another nursing home

2. Discharge to home either with or without services
   a. Discharged home without services - still need to submit the program change form in order to have details about where the patient is going to be living post discharge and termination of services

3. Discharged due to death

When not to enter

1. When a client is discharged to the hospital for a short term stay. As of March, 2021, Nursing Homes can bill for the days before and after a hospital stay without waiting for slips to be updated.
TIPS FOR SUCCESSFULLY ENTERING SLIPS

- Do not enter more than one slip for any single segment
- Be sure to enter all slips, preferably in order of date of service, to ensure the process runs smoothly without a need to contact the nursing home for additional follow up
- Ensure that the SSN entered is correct – incorrect SSNs are common and can cause delays in processing or even denials
- 15 minute time out for entering slips into CSM so if an entry is started but not completed in that time frame, the session will time out and delete any entered details
  - If a slip entry will not be completed within the 15 minute window, clicking Save will reset the 15 timeout.
    - The slip will not be submitted to CSM until all fields are completed and Save is clicked
- Be sure to have all necessary information about the patient available before beginning to enter any slip
DIFFERENT SLIP TYPES

- CSM Admission Form
  - This slip type should be used to report the admission of a Medicaid recipient to a nursing facility for long-term care services.

- CSM Discharge Form
  - This slip type to report the discharge of a Medicaid recipient from a nursing facility.

  * Note that slips should only be entered for instances where a claim will be submitted for payment to the nursing home.
A FEW GENERAL NOTES ABOUT ENTERING SLIPS

- We recommend gathering the necessary information needed before beginning the Discharge Form. You will not be able to save the form and return to it to complete or correct any information.

- After you enter all required information, click the Save button to save the form and submit it electronically to the Department of Human Services Long-Term Care Field Offices for review.

- A small black triangle next to a field name indicates it is a required field.

- The system will alert you if:
  - Data is not entered in the correct format;
  - A required field has not been completed
  - Attempting to leave a form by clicking the browser’s back arrow, navigating to another item on the menu, or opening another form.
  - The system will not accept the form if all required fields are not completed or if any field is not filled out correctly.

- The system will provide a reminder that entered data will be lost if attempting to leave the screen before Saving
Each slip type includes 2 sections that need to be filled out.

- The first section of each form type is the same, requiring the client's specific information to be entered.
- The second section of each form asks questions specific to the slip type and service details.
Many of the fields requesting client information are self explanatory but here are some helpful tips for a few of the fields:

**SSN format:** 999-99-9999

**DOB format:** mm/dd/yyyy

**Facility Listing name:** select appropriate dropdown option. If not listed, you can type your facility name into the Other Facility Name field being sure to enter correctly to avoid delays

**Current Acuity:** Select the level that that patient is in at the time of admission (As of September 1, 2020, this field no longer has an impact on the facility’s ability to bill correctly)

**Admission date:** Enter the date that the patient was admitted to the nursing home using the format mm/dd/yyyy

**Type of insurance:** Select the dropdown option for the patient’s primary insurance

**Corrected form:** If the slip being entered is intended to update the details of a previously entered slip, please add specific details in the comments box to identify what previously entered slip you are intending to correct with any details that would help with identifying the previously entered slip

**Phone** – Enter the phone number for the person from the nursing home who is filling out the slip
The details in this section are intended to provide information about where the patient was located before entering your facility.

**Admitted From:** from the dropdown menu select the setting where the patient was living before coming to your facility.

**Facility name:** if the client is coming from a facility, from the dropdown select the name of the facility or select ‘other’ if the facility is not listed.

**Comments:** if there are any details about the client situation that would be helpful to DHS workers when working the slip, please include those details here. Specifically, if this is a corrected slip, please provide the details for which slip is being corrected.
The details in this section are intended to provide information about the discharge being reported about the patient.

**Discharge Due to Death:** select the appropriate radio button according to the patient’s scenario.

**Discharge to:** from the dropdown menu, select the setting where the patient will reside post discharge.

**Date of Death:** If the patient is being discharged due to death, please enter the date of death in this field – Note that you will need to still enter something into the Discharged to information and should select ‘Other’ from that dropdown.

**Facility Name:** if the client is going to another facility, from the dropdown select the name of the facility or select ‘other’ if the facility is not listed.
WHAT COULD CAUSE A DELAY IN PROCESSING SLIPS?

- Incorrect SSN – common occurrence and something that can easily be avoided if entered correctly – be sure to always double check

- Not entering all slips
  - Entering two admission slips in a row without entering the discharge

- Entering slips after a case has been closed
  - If a slip for discharge due to death is entered and at a later point it is discovered that a slip was never entered for another segment and that slip is subsequently entered
WHAT COULD CAUSE A DELAY IN PROCESSING SLIPS?

- Duplicate slips – please make every effort to record when slips have been entered to ensure that duplicate slips are not entered
  - Entering multiple slips creates work that needs to be reviewed and takes time away from being able to work the slips that are relevant

- Entering place holder slips
  - While it may seem like a great way to hold your place in line in case a patient is going to end up applying for LTSS, this again creates extra work that, in the end, requires follow up and eventually closure taking time away from focusing on the necessary work

- Please be sure to update EOHHS when there are changes to who to contact within the business office.
  - Delays in responding to DHS workers when they reach out to ask about specific questions can slow the process down so it is critical to have the correct contact person to reach out to
CLAIMS AND BILLING
BILLING OVERVIEW

- The process for billing the state and receiving payment requires a slip entry and submission of a claim.
- While all slips are entered into CSM, claims should be entered into the billing software that the nursing home has selected or they can use the free software provided by the state.
- Once the slips are picked up from CSM and entered into Bridges, the state system of eligibility, the details for that segment will be sent to MMIS and, assuming the segment details align, the payment will be deposited into the nursing home’s bank account using EFT.
- For any billing specific questions – for example questions about RUG rates – please contact your DXC Provider Rep. Contact information can be found at the following link: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/welcome_new_provider.pdf.
WHAT CAN SLOW DOWN OR DENY PAYMENT?

- There are several reasons why a payment may be delayed or denied
  - Claim was submitted without a corresponding slip
  - Application has not yet been approved which can be delayed for the following reasons:
    - Missing documents needed to make eligibility decision
    - Complicated financials including significant family assets or transfers in the last 5 years
  - Claim was submitted for a claim more than 10 months old – this requires additional manual work and tracking outside of our system making the process take longer
  - Claims are submitted more than 365 days after the date of service
  - Submitting a claim if the patient has managed care
EXAMPLE OF WHEN A CLAIM WILL NOT BE PAID

Patient has LTSS Eligibility
Eligibility dates – 1/1/2017 – ongoing
Patient enters hospital for a one night stay on 7/15/2020
Nursing home does not submit discharge and admission slips for the client leaving for a night and returning
Nursing home does submit claims for the 7/1/20-7/14/20 stay and for the 7/16/20-7/31/20 segments

How will payment work?
NH will be paid for 7/1/2020-7/14/2020
NH will not be paid for 7/16/2020-7/31/2020 without the discharge and admission slips entered –
  - MMIS uses an edit to stop payments where there is a gap in billed days so will stop the payment for the remainder of July.
  - If the discharge and admission slips had been submitted and entered into Bridges, the update would be sent to MMIS and payment would have been remitted correctly.
NH will be paid for 8/1/2020 – ongoing

How could this have been avoided?
Submitting the discharge and admission slips according to the timeliness guidelines detailed previously, would have triggered the payment for 7/16/2020-7/31/2020
SUMMARY

- Providing all required documents and corresponding slips in a timely fashion leads to a more streamlined end to end process.

- Only submitting slips for segments where a claim will be submitted and refraining from submitting placeholder or duplicate slips creates fewer unnecessary documents for DHS to review, maximizing the time available to work on required slips.

- Take the extra time when initially completing slips and claim to ensure that the correct SSN has been provided, the segment dates on the slips and claims match, and that all slips have been entered – this will ensure the most streamlined process without the need for DHS to contact the nursing home for additional information.

- If questions arise while completing slips do not hesitate to contact DHS by sending an email to dhs.ltss@dhs.ri.gov or calling the coverage line 401-415-8455.
THANK YOU!

- We are so appreciative of the work you do in partnering with us to help ensure that we are all doing our best to help our vulnerable population get the care they need.

- This presentation is just one part of our commitment to continuously improve our process while being sure you have clear guidance to help you be most successful in providing all necessary details to DHS for us to be able to complete our work.
APPENDIX
<table>
<thead>
<tr>
<th>Document</th>
<th>Also Called</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover Sheet</td>
<td>Application for assistance health coverage/Medicaid screen</td>
<td>This form should be completed when submitting an application and corresponding documents for a first time applicant</td>
</tr>
<tr>
<td>DHS-2</td>
<td>Application for assistance</td>
<td>This is the full application for people applying for Long Term Care eligibility. Filling out the application completely helps move the process along most efficiently</td>
</tr>
<tr>
<td>PM-1</td>
<td>Provider medical statement</td>
<td>This form should be filled out by the patient’s medical provider to be used by the OMR unit when assessing the level of care</td>
</tr>
<tr>
<td>AP 70.1</td>
<td>Nursing Home Functional Assessment</td>
<td>This form is filled out by a nursing home social worker and used by OMR when assessing the level of care for the patient</td>
</tr>
<tr>
<td>MA-PAS-1</td>
<td>Level 1 identification for MI and DD - PASSR</td>
<td>This form is filled out by the patient’s medical provider to be used by OMR when assessing PASSR compliance</td>
</tr>
<tr>
<td>DHS - 25</td>
<td>Authorization to obtain or release confidential information</td>
<td>This form is used for release of any non medical information about the client</td>
</tr>
<tr>
<td>DHS – 25M</td>
<td>Authorization for release of health information</td>
<td>This form is used to authorize the release of medical information about the patient</td>
</tr>
<tr>
<td>CP – 12</td>
<td>Notification of recipient choice</td>
<td>Acknowledgement that patient has been informed of and understands option between home care and nursing home care</td>
</tr>
<tr>
<td>Document type</td>
<td>New Application</td>
<td>Change in Financial or Change in Cost of Care</td>
</tr>
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<tr>
<td>Change Form</td>
<td>N/A</td>
<td>✔️</td>
</tr>
</tbody>
</table>
| Slip type     | Admission      | N/A                                         | Admission                 | Discharge                  | Discharge                               

**MARCH 2021**
Rhode Island Health and Human Services
Application for Assistance – Health Coverage/Medicaid Screen

Please read this sheet over if you are applying for health coverage, including Medicaid. If this is the right application for you, answer the questions below and return this form with your completed application. Your answers will help us process your application more effectively.

APPLICANT’S NAME ___________________ SOCIAL SECURITY NUMBER ___________________

What is the right Health Care/Medicaid application for me?
This is the right health care/Medicaid application if you want:

Medicaid long-term services and supports (LTSS). For people who need help with everyday activities and the tasks necessary to live on their own. May be provided in a nursing facility, hospital, assisted living residence, community residences for people with developmental disabilities or chronic conditions, or in someone’s home. OR

Medicaid for elders and adults with disabilities (EAD). For people who need health care EXCEPT for LTSS. Must be 65 or older or 19 to 65 and have a disability and Medicare. Includes Sherwood coverage if working and have a disability. OR

Katie Beckett eligibility for children with serious disabilities/conditions (KBC). KBC coverage for children up to age 19 who have serious disabilities and are cared for at home and do not qualify for Medicaid in another way. OR

This MAY NOT be the right application if you want ONLY:

Medicaid or a private health plan with financial help to cover children, pregnant women, parents/caretakers or adults 19 to 64 who DO NOT have Medicare. You can APPLY ONLINE AT: www.healthryhome.org or call HealthSource RI at 1-855-860-4774.

If this is the right application for you, check all that apply:

☐ Working adult with disabilities seeking Sherwood Plan eligibility.

☐ Medicaid or private health plan and other benefits like child care, food assistance or RI Works.

Applying for Medicaid LTSS and:

☐ Adult with intellectual/developmental disabilities working with Department of Behavioral Healthcare. Developmental Disabilities and Hospitals (BHDDH).

☐ Living in a nursing home, assisted living residence, BHDDH group home or other supportive residence.

Name of facility/residence ___________________ Date of Entry ___________________

☐ Entering a nursing home, assisted living residence, BHDDH group home or other supportive residence.

Name of facility/residence ___________________ Date of Entry ___________________

☐ Living in own home or returning soon to own or someone else’s home.

☐ Already have Medicaid, but looking for LTSS.

☐ Katie Beckett eligibility for a child under age 19.

☐ Working with community agencies, including through the Division of Elderly Affairs (CEA) or BHDDH.

Name of agency ___________________ Contact Information ___________________

☐ Elder or adult with disability (age 19 to 64) eligible for or enrolled in Medicare

☐ I also need help paying my Medicare premiums costs

RETURN THIS SHEET WITH THE COMPLETED APPLICATION FOR ASSISTANCE
Rhode Island Department of Social and Rehabilitative Services
Nursing and Intermediate Care Unit
Social Worker’s Evaluation of need for Care in
A Nursing or Intermediate Care Facility

Name: ___________________________
Date: ___________________________
City: ___________________________
State: ___________________________
Zip: ___________________________

A. PRESENT SITUATION
1. Present Address: ___________________________
   City: ___________________________
   State: ___________________________
   Zip: ___________________________

2. Re-Evaluation Date: ___________________________

B. PHYSICAL AND MENTAL STATUS AND FUNCTIONAL CAPACITIES

1. AMBULATION
   - Walk alone
   - Walk with cane
   - Walk with walker
   - Walk with personal assistance
   - Walk in bed only
   - Bedridden

2. BODY HYGIENE
   - Washes own face, hands, and feet
   - Washes own face, hands, and feet with help
   - Washes own face, hands, and feet with assistance
   - Washes own face, hands, and feet with assistance and help
   - Cannot wash own face, hands, and feet

3. PERSONAL REQUIREMENTS
   - Dress alone
   - Dress with help
   - Dress with help and assistance
   - Dress with help and assistance
   - Cannot dress

4. MENTAL AND EMOTIONAL NEEDS
   - Alert
   - Bewildered
   - Confused
   - Confused
   - Blind

5. VISION
   - Normal vision
   - Normal hearing
   - Failing vision
   - Failing hearing
   - Partially blind
   - Partially deaf
   - Blind
   - Deaf

C. SERVICES REQUIRED
   (Note: If new care, indicate whatever information is known to you)
   If Re-Evaluation, Give Name and position of person in NIC home who is helping to provide this information

D. What attempts have been made to keep the patient in the community, through the use of community resources?

E. General description of patient’s condition and services that must be performed for the patient and what the patient can do for himself or herself:
Section I: Individual Developmental Disabilities

1. Does the individual have a diagnosis of a major mental illness? [Y/N] [Yes/No]
2. Does this individual have any of the following mental illnesses? [Specify]
3. Does the treatment history indicate a psychiatric hospitalization within the past two years? [Y/N] [Yes/No]
4. Does this individual have a high risk of suicide or have a history of suicide attempts? [Y/N] [Yes/No]
5. Has this individual received any of the following mental health services in the past year? [Specify]
6. Does this individual exhibit any of the following behaviors or symptoms not seen within the past six months due to mental illness or substance mental illness? [Specify]
7. Does this individual have a substance use disorder? [Y/N] [Yes/No]

Section II: Mental Status

<table>
<thead>
<tr>
<th>Psychiatric Medication</th>
<th>Beginning Date</th>
<th>Diagnosis</th>
<th>Medication Replaced in the Past 30 Days</th>
</tr>
</thead>
</table>

Section III: Dementia

Does this individual have a primary diagnosis of dementia with co-occurring medical conditions? [Y/N] [Yes/No]

Section IV: Categorical Determination of Severe or Terminal Illness

Does this individual have a terminal illness with the prognosis of a life expectancy of 4 months or their pulmonary symptoms are stable? [Y/N] [Yes/No]

If yes, does the individual have any of the following conditions? [Specify]

Section V: Provision of Emergency and Lifeline

Does this individual need emergency or lifesaving care for seven or more days? [Y/N] [Yes/No]

For Specific Information:

- The individual requires immediate medical attention.
- The individual requires life-sustaining treatment.
- The individual requires a procedure or treatment that is not readily available.

Note: If the individual is determined to be in need of emergency or lifesaving care, the provider must immediately report the individual to the appropriate authorities.
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 ____________________________________________ ____________________________________________

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

Financial
(Specify) ____________________________ (Date) ____________

Social
(Specify) ____________________________ (Date) ____________

Other
(Specify) ____________________________ (Date) ____________

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, 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 addressee ____________________________ Date ____________________________

Name (printed) ____________________________________________ DHS Agency Representative ____________________________ Title ____________________________

District Office Address ____________________________________________ MARCH 2021
DHS-25M

DHS-25M (Rev. 06/21)  
RI DEPARTMENT OF HUMAN SERVICES  
AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION  

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN.

I. 1. ___________________________ hereby voluntarily authorize the disclosure of 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 box I checked in Section VI below)

   ☐ Other (specify): ___________________________

   ☐ Psychotherapy notes ONLY (by checking this box, I waive my psychotherapy-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 DRS 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 photostate 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 SERVICES 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 pt 164], and the Privacy Act of 1974 [5 U.S.C. 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

Signature of Authorized Representative

Relationship to Patient

VI. Specific Information I do NOT want disclosed (check the applicable box(es))

☐ Discharge Summary w/lab data  ☐ Progress Notes  ☐ Laboratory Data  ☐ Psychiatric Exam

☐ History & Physical Examination  ☐ Treatment Plan  ☐ Psychological Test  ☐ Social Service History

☐ Vocational  ☐ Medical  ☐ Educational  ☐ Financial

☐ Minimum Data Set  ☐ Nurses’ Notes  ☐ Care Plans  ☐ Dental Records

☐ Photon/Video/Digital Images  ☐ Billing Statements  ☐ Consultant Reports  ☐ Dietary Records

☐ Emergency Care Records  ☐ X-ray Reports  ☐ Diagnostic Results

Instructions for Completing Form DHS-25M

1. Print legibly in all fields using black ink.

2. Section I – print the name of the patient whose information is to be released.

3. Section II – print the name and address of the person/organization authorized to release the information. Also, provide the name of the person, unit and address that will receive the information.

4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)

5. Section IV – check ONE of the listed boxes:

   a. Entire Record – the patient’s complete medical record except for the sensitive information (e.g., alcohol/drug abuse treatment referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes)

   b. All of the information (except the box I checked in Section VI below) – the patient should check only those boxes the patient does NOT wish to have disclosed

   c. Other (specify) – specific information specified by the patient (e.g., CMS billing, employee health)

   d. Psychotherapy Notes ONLY – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

   Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist’s impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   e. RELEASE OF SENSITIVE INFORMATION – check alcohol/drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases, mental health (other than psychotherapy notes) – patient must check the appropriate box.

6. Section V – sign and date. If a different expiration date is desired, specify a new date.

7. Section V – Authorized Representative (e.g., legal guardian, power of attorney)

8. Section VI – Specific information the patient does NOT want disclosed

9. A copy of the completed Form DHS-25M will be given to the patient.
DEPARTMENT OF HUMAN SERVICES
HOME AND COMMUNITY-BASED CARE WAIVER
NOTIFICATION OF RECIPIENT CHOICE

RECIPIENT NAME: 
ADDRESS: 
CASE NUMBER: 

Recipient Notification
I understand that I have been assessed and found to require the services provided in a Skilled Nursing or an Intermediate Care Facility. I have been offered a choice between in-home community-based care and in-patient care in a Skilled Nursing or an Intermediate Care Facility. I have chosen:

Placement in a Skilled Nursing or Intermediate Care Facility

In-Home Community-Based Care which may include Home Health Services, Homemaker Services, Adult Day Care, and other Medical Assistance program covered services

__________________________________________
Signature of Recipient or Representative Date

MARCH 2021
LTSS CHANGE FORM

Instructions: Please complete this form to report all LTSS Changes. Please submit a signed CP-12, DIS-25 and DIS-25M
Please attach all documents to: Long Term Support and Services P.O. Box 8709 Cruiser, RI 02819. Fax: 401-415-8411 8422.
Coverage email: DISLTSS@ri.gov, Coverage Line: 401-415-8412

Client Information [Fill out completely] Date:

<table>
<thead>
<tr>
<th>Name:</th>
<th>D.O.B.</th>
<th>SSN / MID (circle)</th>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>Power of Attorney or Referring Agency (circle)</th>
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<thead>
<tr>
<th>Phone #</th>
<th>Alternate Phone #</th>
<th>Comments:</th>
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<th>Power of Attorney or Referring Agency Name:</th>
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<th>Power of Attorney or Referring Agency Address:</th>
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<th>Power of Attorney or Referring Agency Telephone/ Email:</th>
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Change / Status [Check all that apply]

- Medicaid to LTSS
  Be sure to attach completed Application

- Financial / Resource Change
  Add details to comment box. Be sure to submit verification documentation.

- Program Change
  Add details to comment box.

- Admitted to Nursing Home
  Add details to the comment box.

- Money Follows the Person
  Add details to the comment box.

- NH Transition
  Add details to the comment box.

- Change of Address [Provide new address including the old State Address]

- Closing

<table>
<thead>
<tr>
<th>Date:</th>
<th>Close: Decedent</th>
<th>Close: Out of State</th>
<th>Withdrawal</th>
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LTSS Currently Enrolled in:

- Client currently does not have LTSS

HCBS

- Preventive
- DIS Core Community

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<tr>
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Nursing Home

- Facility Name:
- Admission Date:
- Discharge Date:

- Eleanor Slater
- FATIMA (LTBH)

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<tr>
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<th>Personal Needs Assessment</th>
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MARCH 2021