**Community Supports Management
Forms Guide**

gainwell

**Gainwell Technologies**

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# Introduction

The Community Supports Management Website was designed to help users enter forms electronically. Users are now able to enter the following forms on the CSM without a need to fax them over to the local DHS office.

- Nursing Home Admission Slips
- Nursing Home Discharge Slips
- Nursing Home Change in Acuity Slips **(This functionality is still currently available on the website but should not be utilized any longer.)**

Electronic entry of these slips allows for more efficient processing and handling of these entries.

Below is an overview of the Nursing Home Forms available on the website (https://www.ricsm.net)

In order to gain access to the CSM Website, all new users must fill out and submit a CSM User ID Form. The form is available on the last 2 pages of this document.

Once the form has been filled out, you can mail the form to the address located on the bottom of Page 2. An original signature must be included on the form in order for it to be processed. Scanned copies will not be accepted for processing.

Once the form has been approved, the user will receive an email with their CSM User ID, a temporary password, and a link to the CSM with some basic instructions on logging in.

# Overview of Forms Available

## CSM Admission Form

This form was designed for health care providers to report the admission of a Medicaid recipient to a nursing facility for long-term care services.

## CSM Discharge Form

This form was designed for health care providers to report the discharge of a Medicaid recipient from a nursing facility.

## CSM Change in Acuity Form

This form was designed for health care providers to report when a client's needs change and the client requires a different level of care. *(This functionality is still currently available on the CSM website but should not be utilized any longer.)*

## CSM Long Term Care Referral Form

This form was designed for health care providers to refer a client for long-term care services.

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# Admission Form Detail



## CSM Admission Form field level help

This form was designed for health care providers to report the admission of a Medicaid recipient to a nursing facility for long-term care services. The Admission Form includes two sections, C*lient Information* and *Admission Information*.

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

**Gather the necessary information you need before beginning the Admission 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.

The system will alert you if:

1. Data is not entered in the correct format;
2. You have not completed a required field; or
3. You attempt to leave the Admission Form by clicking your browser's back arrow, navigating to another item on the menu, or opening another form.

The system will remind you that the data you entered will be lost if you attempt to leave the screen before you **Save** it. The system will not accept the form if all required fields are not completed or if any field is not filled out correctly.

**Fields**

*Client Information*

**SSN:** Enter the client's nine-digit social security number. SSN must be in format 999-99-9999. SSN is a required field.

**Last Name:** Enter the client's last name. Last Name is a required field.

**First Name:** Enter the client's first name. First Name is a required field.

**Middle Initial:** Enter the client's middle initial.

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**Birth Date:** Enter the client's date of birth. Use the form mm/dd/ccyy. Birth Date is a required field.

**Admission Date:** Enter the date of admission to the nursing facility. Use the form mm/dd/ccyy. Admission Date is a required field.

**Facility Listing Name:** Use the drop-down menu to select the name of the nursing facility to which the client was admitted. Facility is a required field.

**Type of Insurance:** Use the drop-down menu to select the client's primary insurance. Type of Insurance is a required field.

**Current Acuity Level:** Use the drop-down menu to select the client's required level of care at the time of admission to the nursing facility. Acuity Level is a required field.

**Corrected Form:** Use the radio button to indicate whether this form is the original notification of this admission or if this is a corrected form. Corrected Form is a required field.

**Person Filling Out Form:** Enter your first and last name here. This is a required field.

**Phone:** Enter your phone number here. Include the area code and your extension (if applicable). Phone is a required field.

**DHS LTC Office:** Use the drop-down menu to select the Department of Human Services Long-term Care Field Office that covers the region where the nursing facility is located. LTC Office is a required field.

*Admission Information*

**All information in this section refers to the setting where the client was <u>before</u> this admission to the nursing facility — whether that was the client's home, a residential facility, another nursing home, or the hospital, or another community setting.**

**Admitted From:** Use the drop-down menu to indicate the setting where the client was <u>before</u> this admission to the nursing home. Admitted From is a required field.

**Facility Name:** If the client was in a facility before being admitted to this nursing home, use the drop-down to enter the name of that facility. If you do not know the name of the facility, you can choose the "Other" option from the drop-down.

**Street 1:** Enter the number and name of the street address where the client was before being admitted to the nursing home. Use the second line if necessary. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**Street 2:** Use this line as necessary to enter additional address information. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**City:** Enter the city where the client was <u>before</u> this admission to the nursing home or use the drop-down box in the field below (**Or Select**) to select a city in Rhode Island. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**State:** Use the drop-down box to select the state where the client was <u>before</u> this admission to the nursing home. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**Zip:** Enter the five-digit zip code of the setting where the client was <u>before</u> this admission to the nursing home. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

# CSM Discharge Form Detail



## CSM Discharge Form field level help

This form was designed for health care providers to report the discharge of a Medicaid recipient from a nursing facility. The Discharge Form includes two sections, C*lient Information* and *Discharge Information*.

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

**Gather the necessary information you need 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.

The system will alert you if:

1. Data is not entered in the correct format;
2. You have not completed a required field; or
3. You attempt to leave the Discharge Form by clicking your browser's back arrow, navigating to another item on the menu, or opening another form.

The system will remind you that the data you entered will be lost if you attempt to leave the screen before you **Save** it. The system will not accept the form if all required fields are not completed or if any field is not filled out correctly.

**Fields**

*Client Information*

**SSN:** Enter the client's nine-digit social security number. SSN must be in format 999-99-9999. SSN is a required field.

**Last Name:** Enter the client's last name. Last Name is a required field.

**First Name:** Enter the client's first name. First Name is a required field.

**Middle Initial:** Enter the client's middle initial.

**Birth Date:** Enter the client's date of birth.  Use the form mm/dd/ccyy. Birth Date is a required field.

**Discharge Date:** Enter the date of discharge from the nursing facility. Use the form mm/dd/ccyy. Discharge Date is a required field.

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**Facility Listing Name:** Use the drop-down menu to select the name of the nursing facility from which the client was discharged. Facility is a required field.

**Current Acuity Level:** Use the drop-down menu to select the client's required level of care at the time of discharge from the nursing facility (hospice, nonskilled, skilled). Acuity Level is a required field.

**Corrected Form:** Use the radio button to indicate whether this form is the original notification of this discharge or if this is a corrected form. Corrected Form is a required field.

**Person Filling Out Form:** Enter your first and last name here. This is a required field.

**Phone:** Enter your phone number here. Include the area code and your extension (if applicable). Phone is a required field.

**DHS LTC Office:** Use the drop-down menu to select the Department of Human Services Long-term Care Field Office that covers the region where the nursing facility is located. LTC Office is a required field.

*Discharge Information*

**All information in this section refers to the setting where the client was <u>discharged to</u> after leaving the nursing home.**

**Discharge Due to Death:** Use the radio button to indicate whether this patient died.

**Date of Death:** Enter the client's date of death. Use the form mm/dd/ccyy.

**Discharged To:** Use the drop-down menu to <u>indicate the setting to which the client was discharged</u> after leaving the nursing home. Discharged To is a required field.

**Facility Name:** If the client was discharged to a facility (for example, hospital, another nursing home), use the drop-down to enter the name of that facility.  If you do not know the name of the facility, please choose the "Other" option from the drop-down list.

**Street 1:** Enter the number and name of the street address where the client was discharged to. Use the second line if necessary. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**Street 2:** Use this line as necessary to enter additional address information.

**City:** Enter the city where the client was <u>discharged to</u> or use the drop-down box in the field below (**Or Select**) to select a city in Rhode Island. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**State:** Use the drop-down box to select the state where the client was <u>discharged to</u> after leaving the nursing home. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**Zip:** Enter the five-digit zip code of the setting where the client was <u>discharged to</u> after leaving the nursing home. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

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# CSM Change in Acuity Form Detail



## Change in Acuity Form field level help

***(This functionality is still currently available on the CSM website but should not be utilized any longer.)***

This form was designed for health care providers to report when a client's needs change and the client requires a different level of care. The Change in Acuity Form includes two sections, *Client Information* and *Change of Acuity Information*.

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

**Gather the necessary information you need before beginning the Change in Acuity 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.

The system will alert you if:

1. Data is not entered in the correct format;
2. You have not completed a required field; or
3. You attempt to leave the Change in Acuity Form by clicking your browser's back arrow, navigating to another item on the menu, or opening another form.

The system will remind you that the data you entered will be lost if you attempt to leave the screen before you **Save** it. The system will not accept the form if all required fields are not completed or if any field is not filled out correctly.

**Fields**

***Client Information***

**SSN:** Enter the client's nine-digit social security number. SSN must be in format 999-99-9999. SSN is a required field.

**Last Name:** Enter the client's last name. Last Name is a required field.

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**First Name:** Enter the client's first name. First Name is a required field.

**Middle Initial:** Enter the client's middle initial.

**Birth Date:** Enter the client's date of birth. Use the form mm/dd/ccyy. Birth Date is a required field.

**Effective Date:** Enter the date the patient's level-of-care needs changed. Use the form mm/dd/ccyy. Effective Date is a required field.

**Facility Listing Name:** Use the drop-down menu to select the name of the nursing facility where the client resides. Facility is a required field.

**Corrected Form:** Use the radio button to indicate whether this form is the original notification of this Change in Acuity or if this is a corrected form. Corrected Form is a required field.

**Person Filling Out Form:** Enter your first and last name here. This is a required field.

**Phone:** Enter your phone number here. Include the area code and your extension (if applicable). Phone is a required field.

**DHS LTC Office:** Use the drop-down menu to select the Department of Human Services Long-term Care Field Office that covers the region where the nursing facility is located. LTC Office is a required field.

*Change of Acuity Information*

**Current Acuity Level:** Use the drop-down menu to select the client's current level of care(hospice, non-skilled, skilled).  Current Acuity Level is a required field.

**Requested Acuity Level:** Use the drop-down menu to select the client's new level of care (hospice, non-skilled, skilled). Requested Acuity Level is a required field

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# Long Term Care Referral Form Detail

## LTC Referral Form

| Print Before Submission | Submit Referral | Return |
|---|---|---|

Date: 10/21/2010

### Applicant Information

SSN or Medicaid ID: ›
Applicant Last Name: ›
Applicant First Name: ›
Middle Initial:
Birth Date: ›
Gender: ›
Primary Language: ›
Marital Status: ›
Diagnosis #1: ›
Diagnosis #2:
Other:
Primary Insurance: ›
Secondary Insurance:
Program Applying For: ›
Services Applying For:

Street: ›
City:
Or Select: ›
State: › RI
Zip: ›
Phone: (401)

### Facility Information

Does the person currently reside in a facility?: › ○ Yes ○ No
Facility Name:

### Contact Information (if different)

Last Name: ›
First Name: ›
Is the address the same as the home address?: ☐
Street: ›
City: ›
Or Select:
State: ›
Zip: ›
Home Phone:
Work Phone:
Cell Phone:
Relationship: ›
Legal Relationship:

### Referral Agency Information

Type:
Name:
Discharge Destination City:
Discharge Destination:
Discharge Destination Facility Name:
Admission Date:
Discharge Date:

Form continued on next page:

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## LTC Referral Form field level help

This form was designed for health care providers to refer a client for long-term care services. When you open a **Referral Form**, the **Date** is automatically filled in with the current date. You can change the date if necessary by highlighting the date and entering a new date in the form mm/dd/ccyy. Referral Date is a required field.

The Referral Form includes sections about the client, additional contacts, the client's primary care doctor, and information about the referring agency or person.

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

**Gather the necessary information you need before beginning the Referral Form. You will not be able to save the form and return to it to complete or correct any information.**

**To print a copy of the form for your records**, click the **Print Before Submission** button.

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

The system will alert you if:

1. Data is not entered in the correct format;

2. You have not completed a required field; or

3. You attempt to leave the Referral Form by clicking your browser's back arrow, navigating to another item on the menu, or opening another form.

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The system will remind you that the data you entered will be lost if you leave the screen before you **Submit** it. The system will not accept the form if all required fields are not completed or if any field is not filled out correctly.

**Fields**

*Applicant Information*

**SSN or Medicaid ID:** Enter the client's nine-digit social security number. SSN is a required field.

**Applicant Last Name:** Enter the client's last name. Applicant Last Name is a required field.

**Applicant First Name:** Enter the client's first name. Applicant First Name is a required field.

**Middle Initial:** Enter the client's middle initial.

**Birth Date:** Enter the client's date of birth.  Use the form mm/dd/ccyy. Birth Date is a required field.

**Gender:** Use the drop-down menu to select the client's gender. Gender is a required field.

**Primary Language**:

**Marital Status:** Use the drop-down menu to select the client's current marital status. Marital status is a required field.

**Diagnosis #1:** Use the drop-down menu to select the client's primary diagnosis. Primary diagnosis is a required field.

**Diagnosis #2:** Use the drop-down menu to select the client's secondary diagnosis, if applicable.

**Other:** Enter a third diagnosis in this field (maximum 25 characters), if applicable.

**Primary Insurance:** Use the drop-down menu to select the client's primary insurance carrier. Primary Insurance is a required field.

**Secondary Insurance:** Use the drop-down menu to select the client's secondary insurance carrier, if applicable.

**Program Applying For:** Use the drop-down menu to identify the program for which the client is applying. Program applying For is a required field.

**Services Applying For:** List any services you anticipate that the client will require, for example, home health aide, meals-on-wheels, medication supervision.

**Street:** Enter the number and name of the client's street address.  Use the second line if necessary. Street is a required field. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**City:** Enter the city or use the drop-down menu (**Or Select**) in the field below to select a city in Rhode Island. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**State:** Use the drop-down menu to select the client's state of residence. Rhode Island is the default. State is a required field. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**Zip:** Enter the client's five-digit zip code. Zip is a required field. This field is automatically populated if Hospice, Hospital, or Nursing Facility is selected.

**Phone:** Enter the client's phone number.

*Facility Information*

**Does this person currently reside in a facility?:** Please answer Yes or No

**Facility Name:** If the client currently lives in a facility, enter the facility's name.  leave this field blank if the client does not currently reside in a facility

### Contact Information (if different)

If the client has additional contact information (for example, a friend or relative) enter that information in this section.

**Last Name:** Enter the contact person's last name.

**First Name:** Enter the contact person's first name.

**Is the address the same as the home address?:** Answer Yes if the address is the same or No if the address is different.

**Street:** Enter the number and name of the contact's street address. Use the second line if necessary.

**City:** Enter the city or use the drop-down menu (**Or Select**) in the field below to select a city in Rhode Island.

**State:** Use the drop-down menu to select the contact's state of residence. Rhode Island is the default.

**Zip:** Enter the contact's five-digit zip code.

**Home Phone:** Enter the contact's home phone number.

**Work Phone:** Enter the contact's work phone number.

**Cell Phone:** Enter the contact's cell phone number.

**Relationship:** Use the drop-down menu to indicate the contact's relationship to the client (for example, son, niece, roommate).

**Legal Relationship:** Use the drop-down menu to indicate the contact's legal status with regard to the client (for example, legal guardian, power of attorney).

### Referral Agency Information

Fill out this section if you are making this referral from a facility or agency, such as a hospital or home health care agency. If not, these fields may be left blank.

**Type:** Use the drop-down menu to identify the type of organization making this referral.

**Name:** Enter the name of the referring organization.

**Discharge Destination City:** Use the drop-down menu to select the Rhode Island city where this client is being referred. For example, if the client is returning to her home or going to a relative's home, enter that city. If the client is going to a nursing home, enter the city where the nursing home is located.

**Discharge Destination:** Use the drop-down menu to select the best description of the client's discharge destination. If you select nursing home, other hospital, or rehab facility, please fill in the name of the facility in the Discharge Destination Facility Name field**.**

**Discharge Destination Facility Name:** Enter the name of the facility to which the client is being discharged, if applicable. This field is only enabled if you select nursing home, other hospital, or rehab facility in the Discharge Destination field.

**Admission Date:** Enter the client admission date. The date must be in the form mm/dd/ccyy.

**Discharge Date:** Enter the client discharge date. The date must be in the form mm/dd/ccyy.

### Person Referring Applicant

**Person Referring Last Name:** Enter the last name of the person referring this client for services.

**Person Referring First Name:** Enter the first name of the person referring this client for services.

**Phone:** Enter the referrer's phone number.

**Alternate Phone:** Enter an alternate phone number for the referrer, if available.

**Email:** Enter the referrer's email address.

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### *Person Completing Form (if different)*

Fill out this section if you — the person completing this form — are not the person referring this client for services (for example, if you are assisting the client's spouse, who is making this referral).

**Is the person completing the form different than the person referring the applicant?:** Please select the checkbox if the person completing the form is different from the person who is referring the applicant.

**Last Name:** Enter your last name.

**First Name:** Enter your first name.

**Phone:** Enter your phone number.

**Alternate Phone:** Enter an alternate phone number to reach you, if you have one.

**Agency:** If you are affiliated with an agency, enter the name of the agency here.

### *Applicant's Primary Care Physician*

**Primary Care Physician Information Available:** Click "Yes" or "No" to indicate whether contact information for the client's primary care physician is available. This is a required field. If "Yes," complete the following fields:

**Last Name:** Enter the client's primary care physician's last name.

**First Name:** Enter the client's primary care physician's first name.

**Phone:** Enter the primary care physician's phone number.

**Fax:** Enter the primary care physician's fax number.

**Street:** Enter the primary care physician's street address. Use the line below if necessary.

**City:** Enter the city or use the drop-down menu (**Or Select**) in the field below to select a city in Rhode Island.

**State:** Use the drop-down menu to select the state (primary care physician's office).

**Zip:** Enter primary care physician's office five-digit zip code.

### *Comments*

**Comments:** Use this space to add any comments that would be useful to the social worker who will review this referral.

# Rhode Island Community Supports Management User ID Request

This form will not be processed without the user's signature on the Confidentiality Acknowledgment page.

**Add New User** ☐      **Change** ☐      **Delete** ☐

**Date Request Needed By**:_____

**Please allow 7-10 business days to process your request**

**User Information (please print):**    (all fields are required to process the request)

Last Name:_____    First Name: _____ Middle Initial: ___

Email Address:_____

Phone Number: _____

Provider or Agency Name: _____

Supervisor Name:  _____

**Please check one:**

| _Group Access CSM_ | | For Admin Use Only |
|---|---|---|
| Community Mental Health Center Provider | ☐ | |
| Connect Care Program | ☐ | |
| DCYF CANS User | ☐ | |
| DEA Case Management | ☐ | |
| Home Health Provider | ☐ | |
| Hospice Provider | ☐ | |
| Hospital Provider | ☐ | |
| HP Operations | ☐ | |
| LTC Manager/Supervisor | ☐ | |
| LTC Worker | ☐ | |
| Nursing Home Provider | ☐ | |
| OMR Reviewer | ☐ | |
| OMR/ OCP/ DEA Support | ☐ | |
| Office of Community Programs | ☐ | |
| PASRR MI Office | ☐ | |
| PASRR MI Resident Review | ☐ | |
| PASRR MR/DD Office | ☐ | |
| State Manager | ☐ | |
| View-Only (Report Developers) | ☐ | |

Access to DCYF CANS Admin ☐

DCYF Approval: _____

State of Rhode Island
Executive Office of Health & Human Services

**Rhode Island Community Supports Management System
Confidentiality Acknowledgment**

As a user of the Rhode Island Community Supports Management System (CSM), I may have access to Protected Health Information (PHI). PHI means any individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, or the past, present or future payment for health care provided to an individual.

By signing below, I acknowledge the following:

EOHHS policies and procedures, Rhode Island law, and federal law prohibit the unauthorized use or disclosure of PHI.

I will not share PHI with other state or provider workforce members or any other individuals unless doing so is necessary to do my job and EOHHS policies or procedures permit the use or disclosure.

I will not attempt to access or look at PHI other than what is required to perform my job.

I will not remove PHI from the CSM or secure areas within my work premises unless doing so is necessary to perform my job.

I will abide by all EOHHS policies and procedures relating to PHI.

Upon leaving the workforce of the state of Rhode Island or its business associates, my access will be terminated.  The business associate organization will notify the appropriate personnel to end access.

After I leave the workforce of the state of Rhode Island or its business associates, I will continue to observe EOHHS policies and procedures with regard to PHI that I had access to while a workforce Member.

I understand that if I violate EOHHS polices or procedures relating to PHI, I may be subject to employment or contractual sanctions, up to and including the termination of state employment or contract, and also may be subject to civil liability or criminal prosecution.


_____          _____
User Signature                                                                  Date


_____
Printed Name


_____
Title


Authorized by(EOHHS Use Only): _____ Date:_____


Submit this form to:

RI Community Supports Management System
c/o Nelson Aguiar, Gainwell Technologies
301 Metro Center Boulevard
Third Floor
Warwick, RI 02886