NURSING HOME SLIPS AND BILLING PROCESS MANUAL

MARCH 2021

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 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

- 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

SLIPS

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 the15 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

SLIP PROCESSING STEP BY STEP INSTRUCTIONS

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

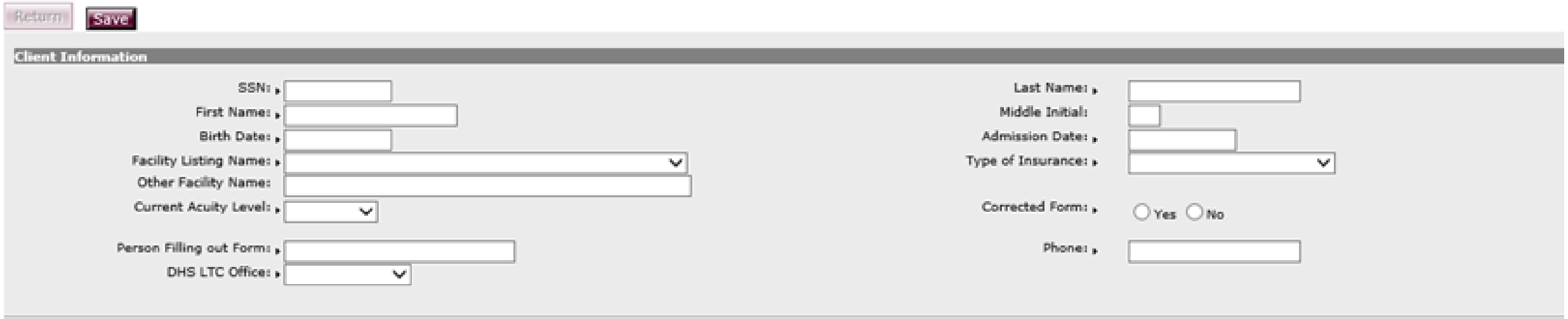
- We recommend gathering the necessary information needed before beginning the Discharge Form. You will not be able to save the form and return to it to complete or correct any information.
- After you enter all required information, click the Save button to save the form and submit it electronically 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**

SLIP TYPES AND PURPOSE

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.

SECTION ONE DETAILS – CLIENT INFORMATION



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)

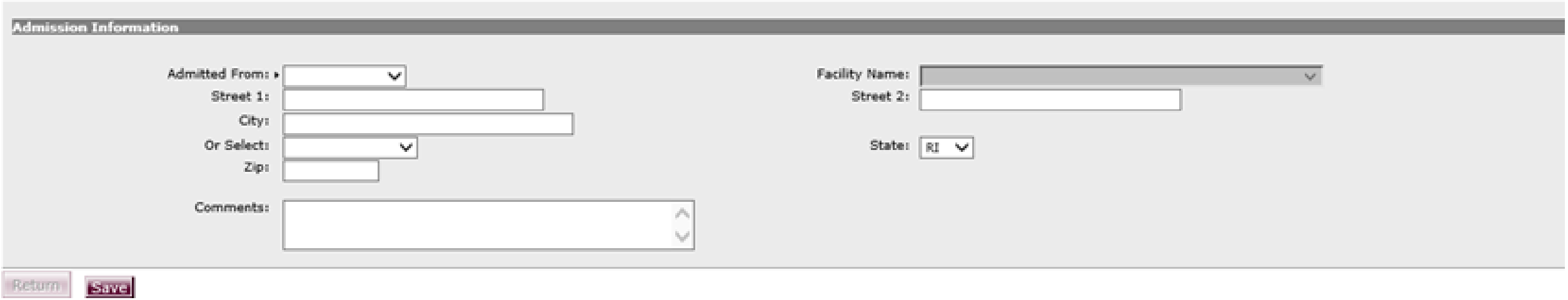
Admission date: Enter the date that the patient was admitted to the nursing home using the format mm/dd/yyyy

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

SECTION 2 – ADMISSION 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.

SECTION 2 – DISCHARGE SLIP

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 dur 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 7/16-7/31/2020 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 7/16/202-7/31/2020

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

DOCUMENT NAMES AND DESCRIPTIONS

Document	Also Called	Purpose
Cover Sheet	Application for assistance health coverage/Medicaid screen	This form should be completed when submitting an application and corresponding documents for a first time applicant
DHS-2	Application for assistance	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
PM-1	Provider medical statement	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
AP 70.1	Nursing Home Functional Assessment	This form is filled out by a nursing home social worker and used by OMR when assessing the level of care for the patient
MA-PAS-1	Level 1 identification for MI and DD - PASSR	This form is filled out by the patient's medical provider to be used by OMR when assessing PASSR compliance
DHS - 25	Authorization to obtain or release confidential information	This form is used for release of any non medical information about the client
DHS – 25M	Authorization for release of health information	This form is used to authorize the release of medical information about the patient
CP – 12	Notification of recipient choice	Acknowledgement that patient has been informed of and understands option between home care and nursing home care

Document type	New Application	Change in Financial or Change in Cost of Care	Program change: HCBS to NH	Program change: NH to HCBS	Program change: NH to Home without services
Cover sheet	✓	N/A	N/A	N/A	N/A
DHS-2	✓	N/A	N/A	N/A	N/A
PM-1	✓	N/A	✓	N/A	N/A
AP 70.1	✓	N/A	✓	N/A	N/A
MA-PAS-1	✓	N/A	✓	N/A	N/A
DHS-25 Must be resubmitted every year and when changing facility	✓	N/A	✓	✓	N/A
DHS-25M Must be resubmitted every year and when changing facility	✓	N/A	✓	✓	N/A
CP-12	✓	N/A	✓	N/A	N/A
Change Form	N/A	✓	✓	✓	✓
Slip type	Admission	MARCH 2021 N/A	Admission	Discharge	Discharge

COVER SHEET

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 coverage EXCEPT for LTSS. Must be 65 or older or 19 to 65 and have a disability and Medicare. Includes Sherlock coverage if working and have a disability **OR**
	Katie Beckett eligibility for children with serious disabilities/conditions (KB). (KB) 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.
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 ON-LINE AT:** www.healthyrhode.ri.gov or call **HealthSource RI at 1-855-840-4774.**

IF THIS IS THE RIGHT APPLICATION FOR YOU, check all that apply:

□ **Working adult with disabilities seeking Sherlock 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 (DEA) 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

PM-1

GW OMR PM 1
3/2014

Instructions to the Examining Provider

Your patient is applying for services from the Department of Human Service (DHS). You are requested to complete this form so that the Office of Medical Review (OMR) can determine the **Level of Care**.

Documentation is required to assist in rendering services that best meet this client's **current** needs, either in a Nursing Facility or with Community Services.

What is needed from you to ensure completion of this application:

1. Please complete this PM-1 thoroughly, returning it to the designated Long Term Care Office in a timely manner. **All sections must be completed.**
2. The PM-1 is essential; other medical information is encouraged, i.e. medication sheets, but not in substitution of this form.

As the examining provider (MD, DO, RNP, PA) you will be assessing your patient's **medical diagnosis, current functional activity, cognitive status and treatments.** (Please use the included codes on page 3.)

Thank you in advance of your assistance.

Activities of Daily Living
(See Current Functional Activities)

TRANSFER: ability to move between surfaces. To or from, bed, chair, wheelchair, standing position excluding to/from bath or toilet (with or without assisted device)

AMBULATION: ability to move between locations in the individual's living environment (with or without assisted device)

BED MOBILITY: ability to reposition body, turning side to side

DRESSING: ability to put on, fasten and take off all items of clothing

BATHING: ability to take a bath, shower, or sponge bath (effectively and thoroughly) and ability to transfer in/out of tub or shower (with or without assistance device)

TOILETING: ability to transfer on/off toilet, cleanses self after elimination, change pad/brief, manage ostomy or catheter, and adjust clothes

EATING: ability to eat and drink using routine or adaptive utensils (this also includes the ability to cut, chew and swallow food)

PERSONAL HYGIENE: ability to comb hair, brush teeth, wash and dry face, hands and perineum

MEDICATION MANAGEMENT: ability to identify and take medications correctly at the right time, route and dose

GW-OMR-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** ☐

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

Current Functional Activity Codes

0 – INDEPENDENT: NO TALK, NO TOUCH
No help or oversight provided to the individual during the activity (with or without the use of an assistive device)
1 – SUPERVISION: TALK, NO TOUCH
Oversight, cueing, and encouragement provided to the individual during the activity (with or without the use of an assistive device)
2 – LIMITED ASSISTANCE: TALK AND TOUCH
Individual highly involved in activity, received physical **guided assistance, no lifting** of any part of the individual
3 – EXTENSIVE ASSISTANCE: TALK, TOUCH AND LIFT
Individual performed part of activity **but** caregiver provides physical assistance to **lift, move or shift individual**
4 – TOTAL DEPENDENCE: ALL ACTION BY CAREGIVER
Individual does not participate in any part of the activity
5 – ACTIVITY DID NOT OCCUR: NO ACTION
The activity was not performed by the individual or caregiver

USE THESE CODES

Activities of Daily Living (ADL's)
____ Bed Mobility
____ Dressing
____ Bathing
____ Toileting
____ Eating
____ Personal Hygiene
____ Medication Management
____ Ambulation
____ Transfer

Instrumental (ADL's)
____ Housekeeping
____ Meal Prep
____ Shopping
____ Laundry

Please circle all that apply:
Cane, Walker, Wheelchair, Bed to Chair, Bedridden, Fall Risk

Can the patient go out unaccompanied? ☐ Yes ☐ No
Can the patient utilize public transportation independently? ☐ Yes ☐ No

COGNITIVE STATUS

Is the patient impaired? ☐ Yes ☐ No **MMSE Score** _____ **BIMS Score** _____ **Date** _____

Cognitive Skills for Daily Decision Making (please check one)
☐ **Independent:** Decisions consistent/reasonable
☐ **Modified Independence:** Some difficulty in new situations only
☐ **Moderately Impaired:** Decision poor/cue/supervision required
☐ **Severely Impaired:** Never/Rarely makes decisions

Behaviors: Please circle all that apply.
Please include level of severity on the line provided: 1 = Mild 2 = Moderate 3 = Severe
____ Disoriented ____ Agitated ____ Wander ____ Elopement ____ Safety Risk
____ Memory Loss ____ Verbally Aggressive ____ Other
____ Resists Care ____ Physically Aggressive

Is patient followed by psych services: ☐ Yes ☐ No **If yes, where?** _____
Has patient been hospitalized for Psychiatric Diagnosis? ☐ Yes ☐ No **(If yes, give details below.)**
Date: _____ **Hospital:** _____ **Diagnosis:** _____
_____

If nursing home placement is medically necessary, will the patient be likely to return to the community within 6 months? ☐ Yes ☐ No

Provider's Name (print) _____ **Signature:** _____ **Date:** _____
(MD, DO, RNP, PA)

For Office Use Only
Social Caseworker: _____ District Office: _____
Date form sent to Provider: _____ Date Received: _____

AP-70.1

AP-70.1
REV 6/78

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

Date_____

Name	Sex	Date of Birth	Case Number
Address or Name of Facility and Classification		If Hospitalized, Name of Hospital	Date of Admission

A. PRESENT SITUATION

1. New Referral ☐ If in Hospital, Name of Referring Person_____
Explain how Client's needs have been met up to now and if consideration has been given to helping the Client remain at Home or to placement with Relatives', etc.

2. Re-Evaluation ☐ Date of Last Authorization_____for_____
Indicate: (A) Length of stay in this home, (B) Attitude towards home, (C) Motivation towards rehabilitation (D) Other pertinent data.

B. PHYSICAL AND MENTAL STATUS AND FUNCTIONAL CAPACITIES (Place check (✓) in appropriate spaces)

1. AMBULATION
_____ alone
_____ with cane
_____ with crutches
_____ with walker
_____ with personal assistance
_____ bed to chair only
_____ bedridden

2. BODY HYGIENE
_____ tends to toilet functions alone
_____ tends to toilet functions with help
_____ occasionally incontinent, bowel ( ) bladder ( )
_____ moderately incontinent, bowel ( ) bladder ( )
_____ chronically incontinent, bowel ( ) bladder ( )

3. PERSONAL REQUIREMENTS
_____ needs little or no help
_____ needs help bathing
_____ needs help dressing
_____ needs help feeding

4. MENTAL AND EMOTIONAL NEEDS
_____ Alert
_____ Disoriented
_____ Forgetful
_____ Confused
_____ Belligerent
_____ Withdrawn

5. SENSES
_____ normal sight
_____ failing sight
_____ partially blind
_____ blind
_____ normal hearing
_____ impaired hearing
_____ partially deaf
_____ deaf

6. OTHER IMPAIRMENTS (SPECIFY)
_____
_____
_____
_____

C. SERVICES REQUIRED

(Note: If New Case, 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)

Name of person giving information_____
Position in NIC home_____

_____Requires only general supervision, incidental medications, enemas, etc.
_____Requires the following services as checked:

( ) Dressings
( ) Catheter Irrigations
( ) Attention to colostomy by home staff
( ) Medications by Injection
( ) Extensive Oral Medications
( ) Physiotherapy
( ) Oxygen Administration
( ) Intravenous of Tube Feedings
( ) Other (Specify):

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/herself:

MA-PAS-I

MA/PAS-1 (Rev.10/2013)

RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Level I Identification for MI and DD

Name of applicant	Social security number	Application date
	- -	- -

Date of birth	Marital status
- - ☐ Male ☐ Female	☐Married ☐Divorced ☐Single ☐Separated ☐Widowed ☐Unknown

Current location of applicant

☐ Psychiatric inpatient ☐ Acute hospital ☐ Home ☐ Residential group home ☐ Nursing facility ☐ Other: _____

Applicant's home address

Payment source

☐ Personal resources ☐ Medicaid approved ☐ Medicaid pending ☐ Commercial health insurance ☐ VA ☐ Medicare

Name and title of person facilitating application	Name and location of current facility

Guardian/legal representative, address and contact information (if applicable)

Primary care physician, address and contact information

Section I : Intellectual & Developmental Disabilities

Does this individual have an Axis II diagnosis of Intellectual Disability (ID) or Developmental Disability (DD) diagnosed or manifested before the age of 22?
☐No ☐Yes

Does this individual have a possible related condition (RC)? ☐No ☐Yes (Specify) ☐Autism ☐Blindness ☐Deafness ☐Cerebral Palsy ☐Epilepsy
☐Head injury ☐Other: _____

Does this individual with a diagnosis of ID, DD or RC have substantial functional limitations with routine activities? ☐No ☐Yes (specify): ☐Self care
☐Understanding and use of language ☐Self direction ☐Mobility ☐Capacity for independent living ☐Learning ☐Decision making

Does this individual have evidence of an intellectual or developmental disability that has not yet been diagnosed? ☐No ☐Yes

Does this individual receive services now or in the past from an agency that serves people with ID and DD? ☐No ☐Yes (list agency):_____

***If any questions in this section are answered "yes" please contact the PASRR State Office of Developmental Disabilities for approval prior to NF admission.**

Section II : Mental Illness

1. Does this individual have a diagnosis of a major mental illness? ☐No ☐Yes (specify) : ☐Schizophrenia ☐Schizoaffective Disorder
   ☐Major Depression ☐Bipolar Disorder ☐Delusional/Psychotic Disorder ☐Paranoid Disorder
2. Does this individual have any of the following mental disorders? ☐No ☐Suspected (specify) ☐Yes (specify): ☐Anxiety ☐Panic ☐Personality Disorder
   ☐Depression (mild or situational) ☐Somatoform Disorder ☐Eating Disorder ☐Other: _____
3. Does the treatment history indicate a psychiatric hospitalization within the past two years? ☐No ☐Yes, date(s):_____
4. Did this individual have a disruptive life episode occurrence because of mental illness within the past two years? ☐No ☐Yes (specify):
   ☐Homelessness/Eviction ☐Law enforcement involvement ☐Altercations/difficulty interacting with others ☐Unstable employment ☐Social isolation
5. Has this individual now or in the past two years received any of the following mental health services? ☐No ☐Yes (specify):
   ☐Community mental health services ☐Inpatient psychiatric hospitalization ☐Psychiatric rehabilitative residence
6. Does this individual exhibit any of the following symptoms or behaviors now or in the past six months due to mental illness or suspected mental illness?
   ☐No ☐Yes (specify all): ☐Self injurious ☐Suicide attempt ☐Suicidal talk and/or gestures ☐History of suicide attempt ☐Physical violence
   ☐Physical threats (harmful) ☐Hallucinations/delusions ☐Illogical comments ☐Excessive irritability ☐Excessive sadness/tearfulness
   ☐Severe loss of appetite ☐Requires assistance with simple tasks ☐Unrealistic fears ☐Serious loss of interest ☐Unable to adapt to life changes
7. Does this individual have substance use disorder? ☐No ☐Yes; If yes, what type of substance? _____
   When did the substance use last occur? ☐Current use ☐Less than a month ☐Less than 1 year ☐Other _____

*** If the answer to question #1 or #2 is "yes" and any of the questions #3-6 is "yes", a PASRR Level II is required prior to approval of NF admission.**

Section II : Mental Illness Continued			
Psychotropic medication	Dosages/mg per day	Diagnosis	Discontinued in the past 6mo
			☐
			☐
			☐
			☐

Section III : Dementia

Does this individual have a primary diagnosis of dementia with collaborative testing results of the progression of dementia? ☐No ☐Yes
☐No, this individual has dementia but it is not a primary diagnosis

* If question above is answered "yes", a dementia exemption from PASRR will be reviewed and determined by the Department of BHDDH.

Section IV : Categorical Determination of Severe or Terminal Illness

Does this individual have a terminal illness with the prognosis of a life expectancy of <6 months and their psychiatric symptoms are stable? ☐No ☐Yes

Does this individual have a severe illness in which he/she could not participate in specialized care and is not a risk for harm to self or others? ☐No ☐Yes

Examples of severe illness include but are not limited to coma, brain stem injury, vent dependent, progressed ALS, progressed Huntington's disease.

*Medical Record documentation of terminal or severe illness needs to be submitted with this form. The nursing facility must update the ID Screen if the individual's medical state improves to the extent that s/he could benefit from services to address their MI or DD/RC needs.

Section V : Provisional Emergency and Delirium

Does this individual need emergency NF care **initiated by protective services** for seven days or less? ☐No ☐Yes(If yes, PS contact):_____

*The admitting NF must submit a "Notification of Need for Resident Review" to BHDDH within 7 days of admission for a Provisional Emergency.

Does this individual have a diagnosis of delirium which interferes with the ability to determine the diagnosis of MI or DD/RC? ☐No ☐Yes

*The NF must update the ID Screen as soon as the delirium clears, but not more than 30 days after admission. If indicated on the new ID Screen, a request for a "Notification of Need for Resident Review" for MI should be submitted on or before the 7th calendar day if the individual is expected to remain in the NF.

Section VI : 30 Day Respite or 30 Day Exemption

Does this individual with a diagnosis of MI or DD/RC require respite care for up to 30 calendar days to provide relief to the family or caregiver? ☐No ☐Yes

Does this individual with a diagnosis of MI or DD/RC require an admission directly from the hospital after receiving acute medical care, and the attending physician certifies that s/he will require less than 30 days of NF services? ☐No ☐Yes If yes, list acute medical diagnosis in this hospital admission that the individual will be treated for in the nursing facility:_____

*30 day exemption will only occur if the symptoms and behaviors are stable and there are no risks to self or others. 30 day exemptions or respite NF admissions will require an updated ID Screen by or before the 30th calendar day if the individual's stay will exceed 30 days.

The information used to screen this individual was obtained from the following resources (please check all that apply):

☐Doctor ☐Nurse ☐Social work ☐Case worker ☐Medical records ☐Family member ☐Friend ☐Applicant ☐Other_____

I certify that all information is true to the best of my knowledge, and I am aware that falsification of this screening will be investigated by the state Medicaid authority, Screener's signature: _____Title: _____Date:_____

DHS-25

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 _____

DHS-25M

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:**

_____
(Name of Person/Organization)
_____
(Address)
_____
(City, State, ZIP)

And is to be provided to:

_____
(Name of Person/Organization)
_____
(Address)
_____
(City, State, ZIP)

III. **The purpose or need for this release of information is:**

☐ I am applying for Medical Assistance
☐ I am applying for other DHS Services
☐ My own personal and private reasons
☐ 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 applications(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**

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
☐ Photos/Videos/Digital Images	☐ Billing Statements	☐ Consultant Reports	☐ Dietary Records
☐ Emergency Care Records	☐ X-ray Reports	☐ Diagnostic Results	

Instructions for Completing Form DHS-25M
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.
2. Section I – print 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 boxes 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., CHS, 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. Theses 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.

CP-12

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

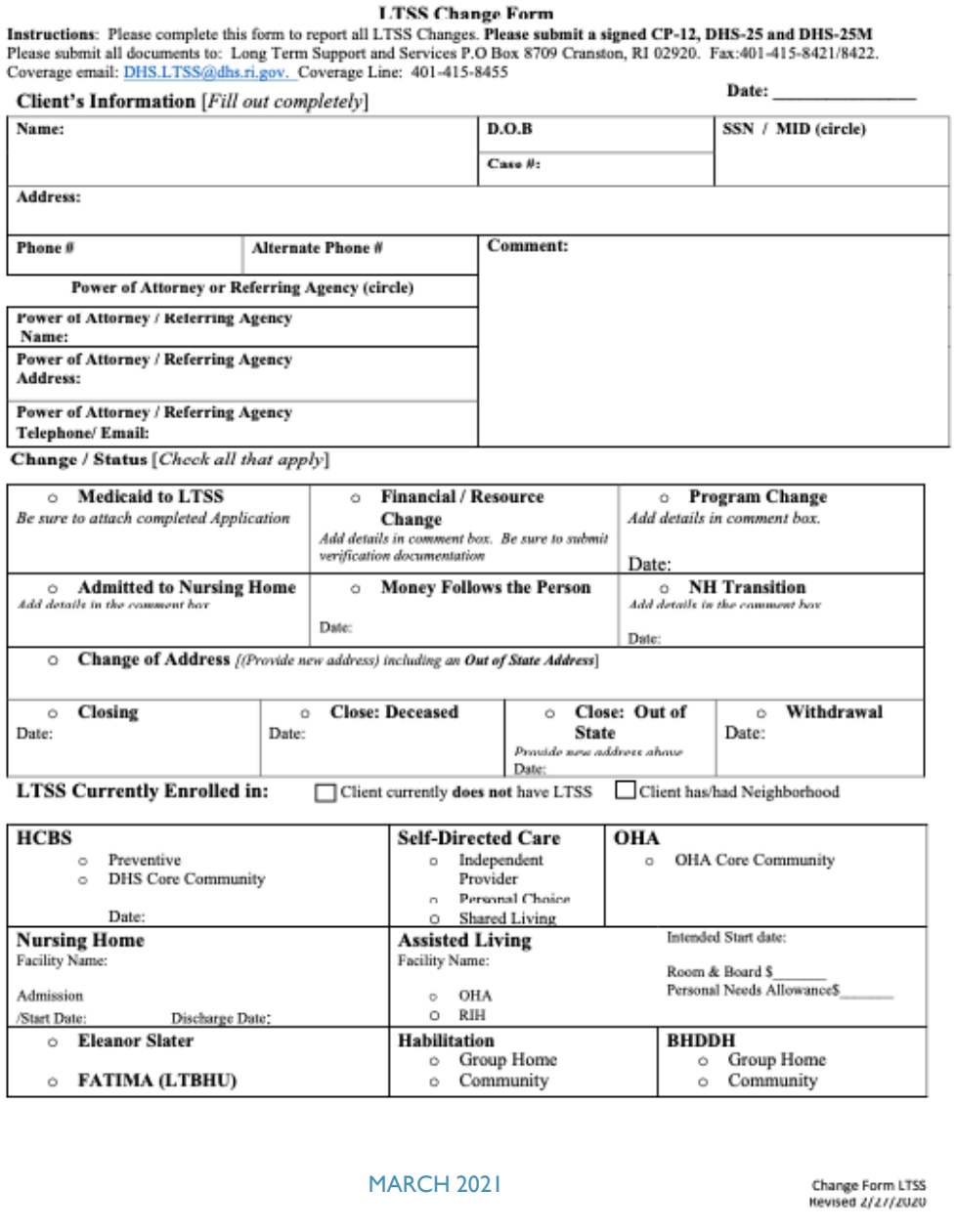
_____ In-Home Community-Based Care which may include Home Health Services, Homemaker Services, Adult Day Care, and other Medical Assistance program covered services

_____

Signature of Recipient or Representative Date

CP-12
3/88

LTSS CHANGE FORM



LTSS Change Form

Instructions: Please complete this form to report all LTSS Changes. **Please submit a signed CP-12, DHS-25 and DHS-25M**
Please submit all documents to: Long Term Support and Services P.O Box 8709 Cranston, RI 02920. Fax:401-415-8421/8422.
Coverage email: DHS.LTSS@dhs.ri.gov. Coverage Line: 401-415-8455

Date: _____

Client's Information [*Fill out completely*]

Name:	**D.O.B** **Case #:**	**SSN / MID (circle)**
Address:		
Phone # / **Alternate Phone #**		**Comment:**
Power of Attorney or Referring Agency (circle)		
Power of Attorney / Referring Agency Name:		
Power of Attorney / Referring Agency Address:		
Power of Attorney / Referring Agency Telephone/ Email:		

Change / Status [*Check all that apply*]

○ **Medicaid to LTSS** *Be sure to attach completed Application*	○ **Financial / Resource Change** *Add details in comment box. Be sure to submit verification documentation*	○ **Program Change** *Add details in comment box.* Date:
○ **Admitted to Nursing Home** *Add details in the comment box*	○ **Money Follows the Person** Date:	○ **NH Transition** *Add details in the comment box* Date:
○ **Change of Address** *[(Provide new address) including an **Out of State Address**]*		
○ **Closing** Date:	○ **Close: Deceased** Date:	○ **Close: Out of State** *Provide new address above* Date:
○ **Withdrawal** Date:		

LTSS Currently Enrolled in: ☐ Client currently **does not** have LTSS ☐ Client has/had Neighborhood

HCBS ○ Preventive ○ DHS Core Community Date:	**Self-Directed Care** ○ Independent Provider ○ Personal Choice ○ Shared Living	**OHA** ○ OHA Core Community
Nursing Home Facility Name: Admission /Start Date: Discharge Date:	**Assisted Living** Facility Name: ○ OHA ○ RIH	Intended Start date: Room & Board $_____ Personal Needs Allowance$_____
○ **Eleanor Slater** ○ **FATIMA (LTBHU)**	**Habilitation** ○ Group Home ○ Community	**BHDDH** ○ Group Home ○ Community

MARCH 2021

Change Form LTSS
Revised 2/11/2020