RI Department of Human Services

LTSS Change Communication Form

Process Name:	Directions for LTSS Change Form
Effective Date:	March 2022
Audience:	DHS, Interagency Partners Agency, NH, Stakeholders

Purpose: The purpose of the LTSS Change Form is to facilitate the communication of changes to a customer's LTSS financial, program, setting and other demographic information. This will allow DHS to update the customer's LTSS record and eligibility to reflect their status.

Process: Stakeholders, customers, interagency partners, attorneys, and Nursing Homes will complete the LTSS change form to indicate a change of program, setting, finances or demographics.

1. LTSS change form should include the customer's demographic information including name, DOB and or Social security number or Medicaid Identification number
2. LTSS change form should include Name and Contact for the person submitting the document under "Person Submitting the Change" to enable DHS staff to follow up with questions and get clarification on the change request as needed.
3. LTSS change form should include the Date of Change and all supporting documentation as needed
    a. If Applying for LTSS should include application, DHS25, DHS25M, CP12 and medicals as needed for the program type applying for.
    b. If Closing LTSS case should include address or documents as needed
    c. If Case Change: Financial, Resource or Demographic change-updated financial, income and resource information or name, address, and demographic information as needed.
    d. If Program change/Setting change: Check the setting the applies and provide updated medicals, PM1, DHS25, DHS25M, CP12, etc.
        i. For program changes, enter client's current program and new program
4. Please utilize comment section to provide additional clarifying information to facilitate DHS's staff ability to quickly process change request.
5. DHS should process change requests within 30 days of receipt. Once processed, DHS will send via fax or email the HCBS-2 turn-around form confirming the change and associated shares/COC, etc. A Benefit Decision Notice is also sent to the address on file reporting changes to the case.

LTSS Change Form

Instructions: Send all documents to: Long Term Support and Services P.O Box 8709 Cranston, RI 02920 or Fax:401-574-9915 or email DHS.LTSS@dhs.ri.gov. For additional questions, the LTSS Coverage Line 401-574-8474.

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

Name:	**D.O.B:** **Case #:**	**SSN / MID** (*circle*)
Address:		
Best Contact Telephone#: / **Alt Phone#:**		**Comment Box:**
Person Submitting the Change: ☐ **Power of Attorney / Legal Guardian** ☐ **State or Community Agency** **Name:** **Address:** **Phone #:** **Email:**		

Purpose for the Change Request

☐ **Applying for LTSS:** *Customer submitting DHS-2 and all supporting documentation for a complete application*	☐ **Close LTSS Case** **Date of Change: _____** ☐ Death ☐ Out of State ☐ Voluntary Withdrawal **Address:**
☐ **Level of Care Renewal / Redetermination**	
☐ **Case Change: Financial, Resource, or Demographic Change**: *Add further details in comment box as needed.* ☐ Change in Finances / Resources ☐ Demographic **Date of Change: _____**	

☐ **Program Change** *[Check the box that applies]* **Date of Change:_____**

Add further details in comment box as needed. Be sure to submit supporting documentation as needed

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