Case Management Agency and Eligibility Information Sharing Form Desk Guide

June 2018

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I. Background Information

Case Management Agencies (CMAs), County Department of Human/Social Services (County) and Medical Assistance (MA) sites routinely communicate information between each other regarding the Medicaid eligibility of individuals seeking and receiving Long-Term Services and Supports (LTSS). Collaboration including efficient and effective communication amongst these entities is crucial for individuals seeking and receiving services. Currently there are various versions of communication forms being used and these forms are sometimes referred to as a DSS-1 (Department of Social Services Information) form.

The Department of Health Care Policy and Financing (Department) reviewed over 25 various DSS-1 forms that are in current use and compiled the content to develop a new standardized fillable PDF form. The newly named, Case Management Agency and Eligibility Information Sharing Form, will be required for all CMAs and MA sites to use effective June 1, 2018. It is the expectation that County Departments of Human/Social Services respond using this form. There is a corresponding desk guide to provide guidance in completing the form.

The form and desk guide are can be accessed on the Department's website:

www.colorado.gov/hcpf/long-term-services-and-supports-case-management-tools

II. Form Example:

COLORADO
Department of Health Care Policy & Financing

Case Management Agency and Eligibility Information Sharing Form

Applicant or Member's Information

First Name: | Last Name: | State ID: | SSN:

Physical Address: | Town/City: | State: | Zip Code:

Mailing Address: | Town/City: | State: | Zip Code:

County: | Home Phone: | Cell Phone: | DOB:

Contact Person: | Contact Phone:

For Case Management Agency

To: | From: | Date:

☐ New Case ☐ CSR/Existing Case Reason for Correspondence: Select

☐ ULTC 100.2 Cert Pages Attached ☐ Please Provide Monthly Income ☐ Please complete HCA grant computation

Approved for the following: Select Waiver: Select

Effective date: Case closed due to: Select

Comments/ Notes:

Reply Requested: ☐ Yes ☐ No Case Manager Signature: _____

For Department of Human/Social Services/Medical Assistance Sites

To: | From: | Date:

Medicaid eligible for: Select Waiver: Select

Gross Monthly Income: Income Source(s): ☐ SSA ☐ SSDI ☐ SSI ☐ Pension ☐ Employment ☐ OAP ☐ AND/AB ☐ Other

☐ HCA Grant Computation Attached

☐ Please send ULTC 100.2 cert. pages

☐ Please complete Level of Care Intake

Ineligible due to: Select Effective date:

Comments/ Notes:

Reply Requested: ☐ Yes ☐ No County Worker Signature: _____

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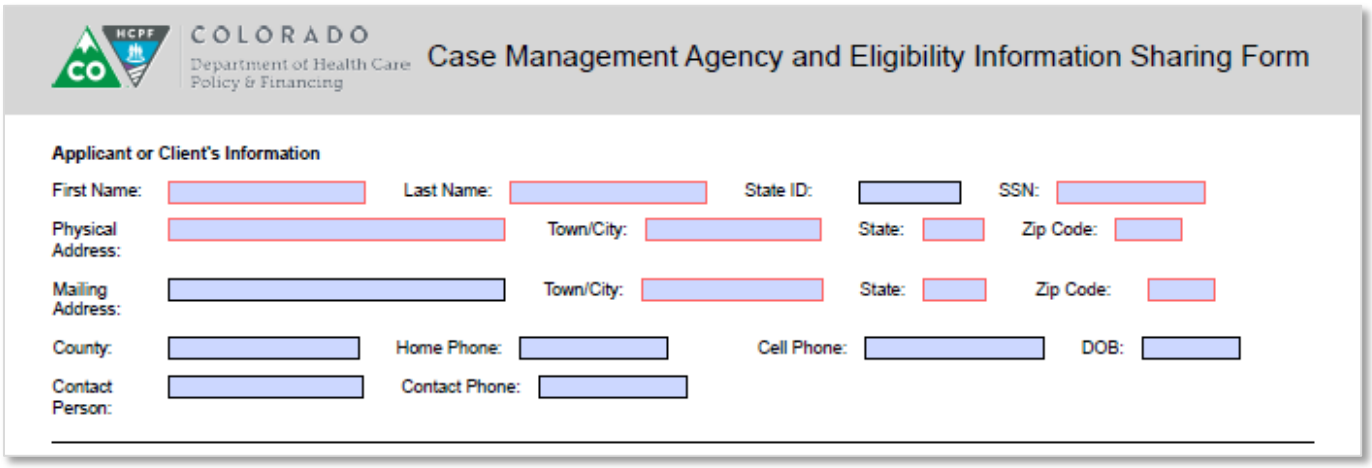
III. Entering Applicant or Client's Information

Applicant or Client's Information: This section must be filled out by either the case manager or county eligibility worker that initiates the communication. **The red boxes are required fields**. Complete non-required fields if the information is known.


COLORADO
Department of Health Care Policy & Financing

Case Management Agency and Eligibility Information Sharing Form

Applicant or Client's Information

First Name: Last Name: State ID: SSN:

Physical Address: Town/City: State: Zip Code:

Mailing Address: Town/City: State: Zip Code:

County: Home Phone: Cell Phone: DOB:

Contact Person: Contact Phone:

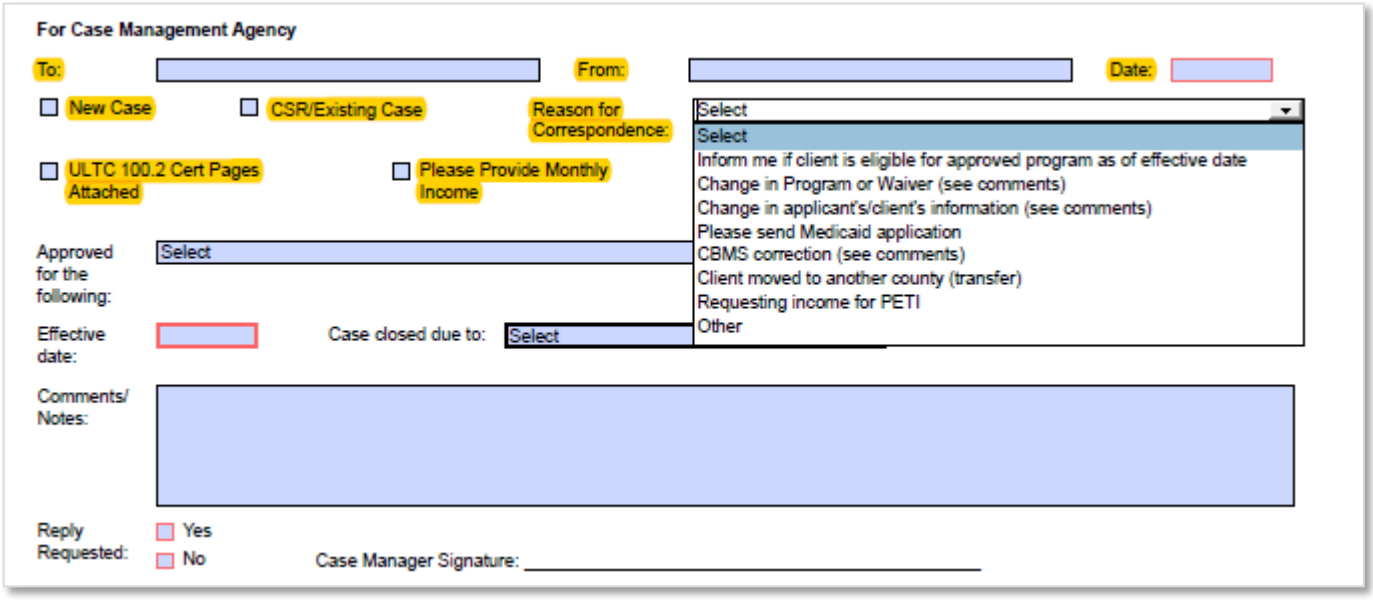
IV. Entering Case Management Agency Information

To, From and Date: In the "To" field the case manager will enter the name of the county eligibility worker or unit they are sending the Case Management Agency and County Information Sharing form to. In the case that the county has a specialized unit rather than assigned county eligibility workers, the CMA can enter the name of the unit in the "To" field (example Long Term Care Unit or LTC Unit). Next, the individual from the CMA will enter their name and the date they are sending the form.

Case status: Check either box "New Case" or "CSR/Existing Case" accordingly.

Cert Pages and Monthly Income: When attaching the ULTC Certification pages, check the corresponding box. When requesting the individual's monthly income, check the corresponding box.

Reason for Correspondence: Select an option from the drop-down items. If the reason for your correspondence is not listed, select "other" and describe your reason in the comments/notes box.


For Case Management Agency

To: From: Date:

☐ New Case ☐ CSR/Existing Case Reason for Correspondence: Select

☐ ULTC 100.2 Cert Pages Attached ☐ Please Provide Monthly Income

Approved for the following: Select

Effective date: Case closed due to: Select

Comments/ Notes:

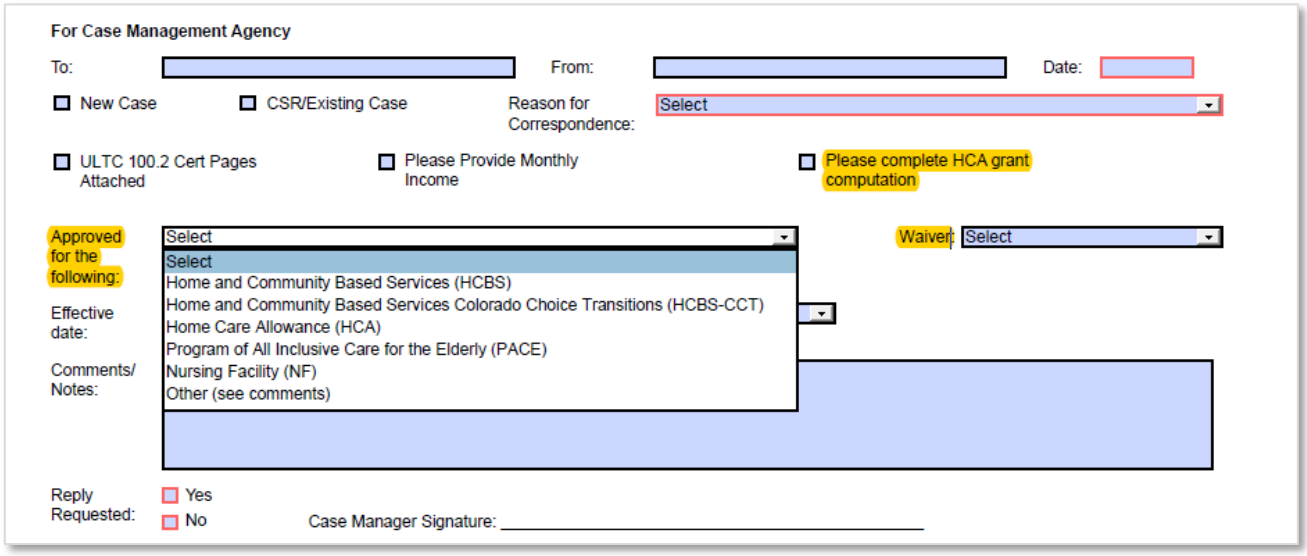
Reply Requested: ☐ Yes ☐ No Case Manager Signature: _____

Select
Inform me if client is eligible for approved program as of effective date
Change in Program or Waiver (see comments)
Change in applicant's/client's information (see comments)
Please send Medicaid application
CBMS correction (see comments)
Client moved to another county (transfer)
Requesting income for PETI
Other

HCA grant computation: Check the HCA grant computation box if you are requesting the completion of the HCA grant computation.

Approved for the following: If you select the "Inform me if client is eligible for approved program as of effective date" option from the Reason for Correspondence menu, an option from the "Approved for the following" drop-down items **must** also be selected.

Waiver: If you select approval for either "Home and Community Based Services (HCBS)" or "Home and Community Based Services Colorado Choice Transitions (HCBS-CCT)" the specific Waiver that the individual is approved for must also be selected from the "Waiver" drop-down menu. *Please note CCT is only available for the following Waivers: HCBS-BI, HCBS-CMHS, HCBS-DD, HCBS-EBD, and HCBS-SLS.*



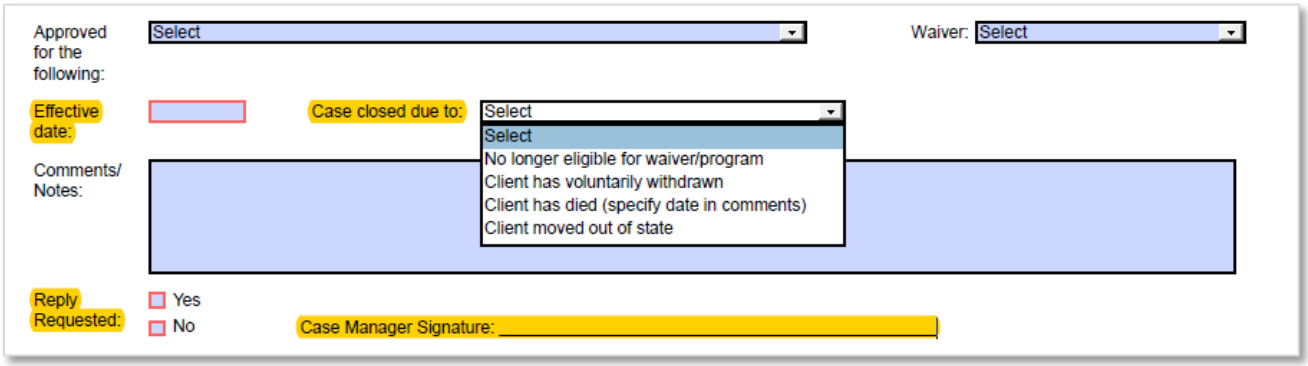
Effective Date: This is a required field. Please fill out an effective date for all forms. This effective date will also be used for case closures.

Case closed due to: If you are requesting that the case be closed, please select an option from the drop-down items.

Comments/Notes: Use the text box for any details pertaining to your reason for correspondence.

Reply Requested: When requesting that the county reply, check the box that corresponds with "Yes." When a reply from the county is not needed, check the box that corresponds with "No."

Case Manager Signature: The individual completing the form should sign the form. Signing the form electronically or printing the completed form and using a wet signature are both acceptable.

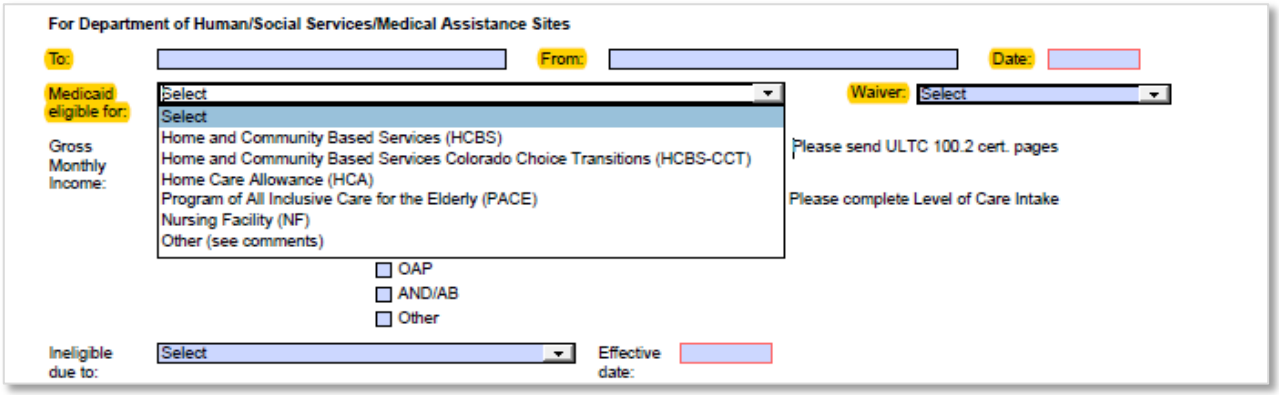


V. Entering County Department of Human/Social Services/Medical Assistance Sites Information

To, From and Date: In the "To" field the county eligibility workers will enter the name of the case manager or agency they are sending the Case Management Agency and County Information Sharing form to. In the case that the county eligibility worker does not know the case manager's name, please enter the name of the case management agency. Next the county eligibility worker will enter their name and the date they are sending the form.

Medicaid eligible for: Select an option from the drop-down menu.

Waiver: If you select approval for either "Home and Community Based Services (HCBS)" or "Home and Community Based Services Colorado Choice Transitions (HCBS-CCT)" the specific Waiver that the individual is approved for must also be selected from the "Waiver" drop-down menu.

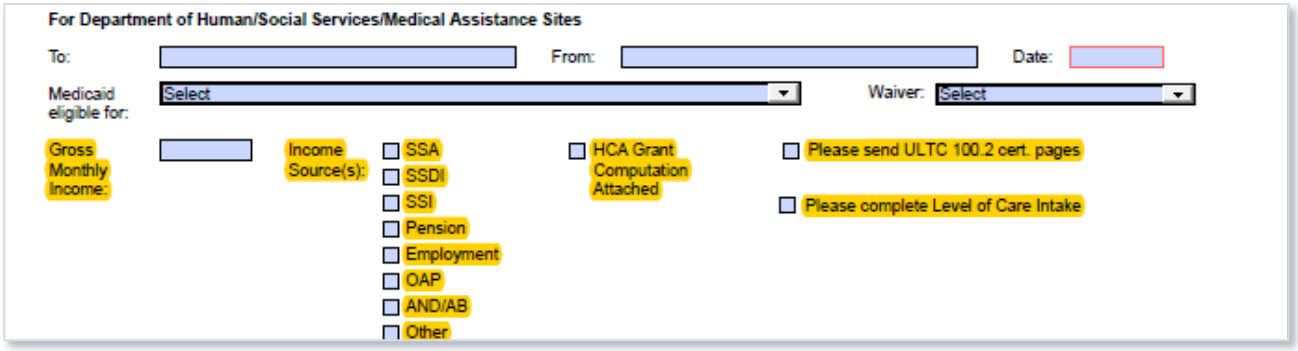


Gross Monthly Income and Income Source: Enter the individual's gross monthly income and the individual's income source(s). If the individual has more than one source of income, check all boxes that apply.

HCA Grant Computation: Check the HCA grant computation box if you are attaching the completed HCA grant computation.

ULTC 100.2 cert pages: Check the ULTC 100.2 certification pages box if you are requesting the CMA send you the ULTC 100.2 certification pages.

Level of Care Intake: Check the Level of Care Intake box if you are requesting the CMA complete a Level of Care Intake.



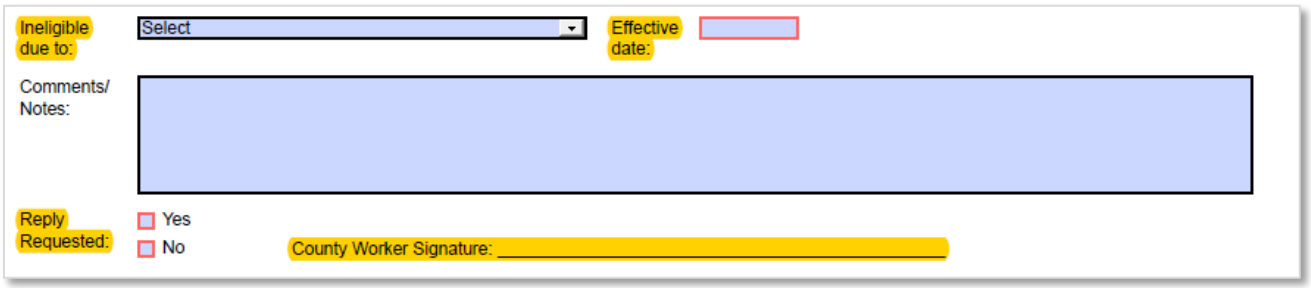
Ineligible due to: When an individual is ineligible for a program, select the reason for their ineligibility from the drop-down menu. If the reason is not listed, select “other” and provide details in the comments/notes box.

Effective date: This is a required field. Please fill out an effective date for all forms. This effective date will also be used for case closures.

Comments/Notes: Use this text box for any details pertaining to your reason for correspondence.

Reply Requested: When requesting that the CMA reply, check “Yes.” When a reply from the CMA is not needed, check “No.”

County Worker Signature: The individual completing the form should sign the form. Signing the form electronically or printing the completed form and using a wet signature are both acceptable.



VI. Sending the Form

Please continue your current method of correspondence when sending the Case Management Agency and County Information Form.