

Financial / Social Services Communication

DATE

Required: ☐ New Service ☐ Service/Program Change ☐ Functional Assessment Completed
☐ Address / Phone Change ☐ Other (see comments below)

NOTE: Do not send this form to financial for MAGI clients unless the client is applying for a HCBS waiver.

TO		OFFICE NAME	
FROM	TELEPHONE NUMBER	OFFICE NAME	
CLIENT NAME	TELEPHONE NUMBER	DATE OF BIRTH	ACES CLIENT ID NUMBER
CLIENT STREET ADDRESS (INCLUDE APT. UNIT OR ROOM NUMBER)		CITY	STATE ZIP CODE
CLIENT MAILING ADDRESS (IF DIFFERENT THAN STREET ADDRESS)		CITY	STATE ZIP CODE
<input type="checkbox"/> Client remains functionally eligible <input type="checkbox"/> No change in service <input type="checkbox"/> Client is no longer functionally eligible - Case Closed:		NECESSARY SUPPLEMENTAL ACCOMMODATION (NSA): <input type="checkbox"/> YES <input type="checkbox"/> NO DESCRIBE: LEGAL DECISION MAKER: <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: <input type="checkbox"/> POA <input type="checkbox"/> GUARDIAN DESCRIBE:	

Nursing Facility

☐ Admission / Date of admit: _____ Date of request for Level of Care: _____
 NFLOC criteria met? ☐ Yes ☐ No
 Likely to meet / exceed 30 days? ☐ Yes ☐ No (do not select "Yes" if bed hold has been authorized)
 Name of Nursing Facility: _____ Facility ProviderOne ID: _____
 Home Maintenance Allowance (HMA)? ☐ Yes ☐ No
 HMA Date: _____
☐ Discharged / Date of discharge: _____ Transitioned with services: ☐ Yes (complete Service section) ☐ No

Services

☐ Need medical redetermination (e.g., MAGI closures) ☐ NGMA request / in-process: _____
☐ Please send DSHS 07-104 to indicate if client is a Fast Track candidate.

PROGRAM	EFFECTIVE DATE	PROGRAM	EFFECTIVE DATE
<input type="checkbox"/> CFC	_____	<input type="checkbox"/> PACE – ProviderOne ID: ..	_____
<input type="checkbox"/> MPC	_____	<input type="checkbox"/> State Funded LTC for Non-Citizens (L04 / L24) .	_____
<input type="checkbox"/> COPEs	_____	<input type="checkbox"/> State Funded MCS Residential (A01 / A05)	_____
<input type="checkbox"/> NEW FREEDOM	_____	<input type="checkbox"/> RSW	_____
<input type="checkbox"/> MAC	_____	<input type="checkbox"/> LTSS Presumptive Eligibility (PE)	_____
<input type="checkbox"/> TSOA	_____		
<input type="checkbox"/> RCL	_____	Initial due date of TSOA application: _____	
		End date of RCL demo year: _____	

☐ Fast Track (also select CFC, MPC, RSW, or COPEs above) NOTE: FT not allowed for New Freedom, PACE, or any MAGI clients

Setting: ☐ In-home ☐ Residential

Residential Rate:

ACES CODE
 SETTING FAC TYPE LVG ARR

Total Daily Rate: \$ _____ (include CARE rate and any other approved add-on such as ETR, ECS and SDCP in the total daily rate amount)

☐ AFH FH FH
☐ AL AF DC
☐ ARC AF CN
☐ EARC AF DC
☐ ESF AF ES

Facility Name: _____
 Facility Address: _____
 Facility Telephone: _____
 Facility ProviderOne ID: _____

COMMENTS