



DATE

Financial Communication to Social Services

FROM: NAME	PHONE NUMBER	ORGANIZATION
------------	--------------	--------------

1. Client Information

CASE NAME	PHONE NUMBER	MESSAGE NUMBER	ACES ID
ADDRESS	CITY	STATE	ZIP CODE

2. Case Information

<input type="checkbox"/> Equal Access (NSA) Accommodation Plan:	<input type="checkbox"/> Medicare eligible (has or will have Part D co-pays)
<input type="checkbox"/> Limited English Proficiency preferred language:	Civil Transitions Program (conditionally eligible): <input type="checkbox"/> Yes Start Date _____
Application date: _____ <input type="checkbox"/> Approved <input type="checkbox"/> Withdrawn <input type="checkbox"/> Active Medicaid <input type="checkbox"/> Active TSOA <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/> Over resources <input type="checkbox"/> Functional eligibility determination <input type="checkbox"/> Asset transfer penalty period: _____ to _____ <input type="checkbox"/> Verification due date: _____ <input type="checkbox"/> Other _____	

EXPENSES (FOR DDA USE ONLY)

Court ordered fees: Guardian \$ _____; Attorney \$ _____

Medical \$ _____

DDA Room and Board ETR Request (CRM, please approve or deny on 15-345). Total ETR amount \$ _____

COMMENTS:

3. Representative

NAME	REPRESENTATIVE TYPE
ADDRESS	<input type="checkbox"/> Authorized representative
CITY	<input type="checkbox"/> Attorney-in-fact
STATE	<input type="checkbox"/> Legal guardian
ZIP CODE	<input type="checkbox"/> Representative payee
PHONE NUMBER (AREA CODE)	<input type="checkbox"/> Parent / Spouse
EMAIL ADDRESS	

4. Service Request

<p>Meets NFLOC? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Nursing Facility <input type="checkbox"/> Home Maintenance Allowance <input type="checkbox"/> TSOA <input type="checkbox"/> MAC</p> <p><input type="checkbox"/> MPC / CFC <input type="checkbox"/> In-home <input type="checkbox"/> Residential</p> <p><input type="checkbox"/> HCS / DDA HCB Waiver <input type="checkbox"/> In-home <input type="checkbox"/> Residential</p> <p><input type="checkbox"/> Ongoing Additional Requirements (indicate type of OAR in comments)</p> <p><input type="checkbox"/> Non-grant Medical Assistance (NGMA) packet is needed for disability determination</p> <p>State Funded Services</p> <p><input type="checkbox"/> LTC for non-citizens (preapproval needed) <input type="checkbox"/> In-home <input type="checkbox"/> Residential <input type="checkbox"/> NF</p> <p><input type="checkbox"/> MCS residential <input type="checkbox"/> MCS NF</p> <p><input type="checkbox"/> Client is a good candidate for Fast Track? <input type="checkbox"/> Yes <input type="checkbox"/> No, and why not?</p> <p>Potentially eligible for: <input type="checkbox"/> MPC <input type="checkbox"/> CFC <input type="checkbox"/> Waiver <input type="checkbox"/> Other</p>	<p style="text-align: center;">For HCS Use ONLY</p> <p>This section is only for referrals to designated WSH / ESH and NGMA / Incapacity / SSI facilitation social workers.</p> <p><input type="checkbox"/> ABD case disability / HEN incapacity determination</p> <p><input type="checkbox"/> SSI Facilitation</p> <p><input type="checkbox"/> WSH / ESH</p> <p><input type="checkbox"/> Other (indicate specific request in comments)</p>
--	--

5. Financial Eligibility Determination

<input type="checkbox"/> Financially eligible for CN (MPC or CFC) <input type="checkbox"/> Financially eligible for CN (CFC, but not financially eligible for MPC) <input type="checkbox"/> Financially eligible for CN (MAC) <input type="checkbox"/> Financially eligible for HCBS waiver <input type="checkbox"/> HCBS waiver rules are needed for eligibility (not eligible for CFC only) <input type="checkbox"/> Financially eligible for MCS (state-funded residential / NF (A01/A05)) <input type="checkbox"/> Financially eligible for LTSS for non-citizens (L04 / L24) <input type="checkbox"/> Financially eligible for TSOA	PROJECTED DATE OF FINANCIAL ELIGIBILITY		
	ESTIMATED AMOUNT OF CLIENT RESPONSIBILITY		
	MONTH 1	MONTH 2	MONTH 3
	\$	\$	\$

6. Comments

--

7. Client Responsibility Overpayment / Underpayment

Overpayment / Underpayment (client reimbursement) notification. WAC reference: Chapter 182-515 WAC, WAC 182-513-1315, WAC 182-504-0100, WAC 182-504-0105, WAC 182-504-0120

REASON FOR OVERPAYMENT / UNDERPAYMENT		CLIENT OR DEPARTMENT CAUSED? <input type="checkbox"/> Client <input type="checkbox"/> Department	CHANGE REPORTED TIMELY? <input type="checkbox"/> Yes <input type="checkbox"/> No
MONTH / YEAR	PREVIOUS CLIENT RESPONSIBILITY	CORRECT CLIENT RESPONSIBILITY	OVERPAYMENT / UNDERPAYMENT AMOUNT