Washington State Department of Social & Health Services
Transforming lives

HOME AND COMMUNITY SERVICES (HCS)
AREA AGENCIES ON AGING (AAA)
DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Financial Communication to Social Services

DATE

FROM: NAME	PHONE NUMBER	ORGANIZATION

1. Client Information

CASE NAME	PHONE NUMBER	MESSAGE NUMBER	ACES ID

ADDRESS | CITY | STATE | ZIP CODE

2. Case Information

☐ Equal Access (NSA) Accommodation Plan:

☐ Medicare eligible (has or will have Part D co-pays)

☐ Limited English Proficiency preferred language:

Civil Transitions Program (conditionally eligible): ☐ Yes Start Date

Application date: _____ ☐ Approved ☐ Withdrawn ☐ Active Medicaid ☐ Active TSOA

☐ Denied
- ☐ Over resources
- ☐ Asset transfer penalty period: _____ to _____
- ☐ Other _____

☐ Pending
- ☐ Functional eligibility determination
- ☐ Verification due date: _____

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

ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER (AREA CODE) | EMAIL ADDRESS

REPRESENTATIVE TYPE
- ☐ Authorized representative
- ☐ Attorney-in-fact
- ☐ Legal guardian
- ☐ Representative payee
- ☐ Parent / Spouse

4. Service Request

Meets NFLOC? ☐ Yes ☐ No

☐ Nursing Facility ☐ Home Maintenance Allowance ☐ TSOA ☐ MAC

☐ MPC / CFC ☐ In-home ☐ Residential
☐ HCS / DDA HCB Waiver ☐ In-home ☐ Residential

☐ Ongoing Additional Requirements (indicate type of OAR in comments)
☐ Non-grant Medical Assistance (NGMA) packet is needed for disability determination

State Funded Services

☐ LTC for non-citizens (preapproval needed) ☐ In-home ☐ Residential ☐ NF
☐ MCS residential ☐ MCS NF

For HCS Use ONLY

This section is only for referrals to designated WSH / ESH and NGMA / Incapacity / SSI facilitation social workers.

- ☐ **ABD case disability / HEN incapacity determination**
- ☐ **SSI Facilitation**
- ☐ **WSH / ESH**
- ☐ **Other (indicate specific request in comments)**

☐ Client is a good candidate for Fast Track? ☐ Yes ☐ No, and why not?

Potentially eligible for: ☐ MPC ☐ CFC ☐ Waiver ☐ Other

5. Financial Eligibility Determination

- ☐ Financially eligible for CN (MPC or CFC)
- ☐ Financially eligible for CN (CFC, but not financially eligible for MPC)
- ☐ Financially eligible for CN (MAC)
- ☐ Financially eligible for HCBS waiver
- ☐ HCBS waiver rules are needed for eligibility (not eligible for CFC only)
- ☐ Financially eligible for MCS (state-funded residential / NF (A01/A05)
- ☐ Financially eligible for LTSS for non-citizens (L04 / L24)
- ☐ 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? ☐ Client ☐ Department	CHANGE REPORTED TIMELY? ☐ Yes ☐ No
MONTH / YEAR	PREVIOUS CLIENT RESPONSIBILITY	CORRECT CLIENT RESPONSIBILITY	OVERPAYMENT / UNDERPAYMENT AMOUNT