Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION

# 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

☐ Client remains functionally eligible
☐ No change in service
☐ Client is no longer functionally eligible - Case Closed:

NECESSARY SUPPLEMENTAL ACCOMMODATION (NSA): ☐ YES ☐ NO DESCRIBE:

LEGAL DECISION MAKER: ☐ YES ☐ NO TYPE: ☐ POA ☐ 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 |
|---|---|---|---|
| ☐ CFC | | ☐ PACE – ProviderOne ID: _____ | |
| ☐ MPC | | ☐ State Funded LTC for Non-Citizens (L04 / L24) | |
| ☐ COPES | | ☐ State Funded MCS Residential (A01 / A05) | |
| ☐ NEW FREEDOM | | ☐ RSW | |
| ☐ MAC | | ☐ LTSS Presumptive Eligibility (PE) | |
| ☐ TSOA | | ☐ Civil Transitions (conditionally eligible) | |
| ☐ 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

| SETTING | ACES CODE FAC TYPE | LVG ARR |
|---|---|---|
| ☐ AFH | FH | FH |
| ☐ AL | AF | DC |
| ☐ ARC | AF | CN |
| ☐ EARC | AF | DC |
| ☐ ESF | AF | ES |

Residential Rate:
Total Daily Rate: $_____ (include CARE rate and any other approved add-on such as ETR, ECS and SDCP in the total daily rate amount)
Facility Name: _____
Facility Address: _____
Facility Telephone: _____
Facility ProviderOne ID: _____

COMMENTS