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| Transforming Lives.png | 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 | | | | | | | | | | | |
| 1. **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 Start Date (conditionally eligible):  Yes | | | | | | | |
| Application date:   Approved  Withdrawn  Active Medicaid  Active TSOA  Denied  Pending  Over resources  Functional eligibility determination  Asset transfer penalty period:  to   Verification due date:  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: | | | | | | | | | | | |
| 1. **Representative** | | | | | | | | | | | |
| NAME | | | | | | | REPRESENTATIVE TYPE  Authorized representative  Attorney-in-fact  Legal guardian  Representative payee  Parent / Spouse | | | | |
| ADDRESS CITY STATE ZIP CODE | | | | | | |
| PHONE NUMBER (AREA CODE) | | EMAIL ADDRESS | | | | |
| 1. **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 | | | | | | | | | | | |
| 1. **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 |
| **$** | | | **$** | | | **$** |
| 1. **Comments** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 1. **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 | | |
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