|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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  ACES CODE  SETTING 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 | | | | | | | | |