



LTSS Nursing Home Facility to Facility Transfers And/Or Change Request

Instructions: Please only use this form if client is active on LTSS and the LTSS recipient transfers between nursing facilities or the other changes listed below. If client is not active on LTSS, please use an application to apply. Please do not use this form to apply for LTSS.

Form can be sent to DHS via email: DHS.LTSS@dhs.ri.gov, Fax: 401-574-9915 or PO Box 8709 Cranston, RI

Client's Information: [Be sure to fill out from completely] Date: _____

Name:		D.O.B:	SSN / MID (circle)
		Case #:	
Address:			
Best Contact Telephone#:	Alt Phone#:	Comment Box:	
Person Submitting the Change:			
<input type="checkbox"/> Power of Attorney / Legal Guardian <input type="checkbox"/> Agency Name: Address: Phone #: Email:			

Has the nursing home checked the Health Care portal to ensure client is already active on LTSS nursing home services? Yes _____ No _____

If you checked no above, go back to please check portal. **If client is not active on LTSS, please do not use this form. You should follow the new application process.**

Purpose of completing the form: [Fill out what applies to your request]

<input type="checkbox"/> Facility Transfer-Moving from one nursing home to another: [ensure client did not go home to community over 30 days between facilities] Prior Facility Name: _____ New Facility Name: _____ Discharge Date from Prior Facility: _____ Admission Date to New Facility: _____ Please ensure your slips are in Health Care Provider Portal.
<input type="checkbox"/> Billing/Segments Issue: [case is already active for your facility but there is an issue with billing, please describe issue below. Be specific with issue and dates in question.]
<input type="checkbox"/> Cost of Care Issue/Applied income: [case is already active for your facility but there is an issue with COC/Applied Income Calculation, please describe issue below. Be specific with issue and dates in question. (complete COC calculator and submit with this form)]

If the issue you are reporting is not listed above, please ensure you are using the correct form.

I attest that the changes reported on this form are true and correct. I understand that I am responsible for reporting changes accurately and timely. I understand that this information will be used to determine or redetermine eligibility for benefits.

Printed Name: _____ Signature: _____ Date: _____

