LTSS Setting and Program Change Reporting Form

Instructions: Please use this form if client is already active on LTSS and would like to report a setting/program change within the LTSS program. If client is not already active on LTSS, please use an application to apply. Please do not sure this form to apply for LTSS.

Form can be sent to DHS Via email: DHS.LTSS@dhs.ri.gov , Fax: 401-574-9915 or POB 8709 Cranston, RI 02920

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

Name:		**D.O.B:**	**SSN / MID** (*circle*)
		Case #:	
Address:			
Best Contact Telephone#:	**Alt Phone#:**	**Comment Box:**	
Person Submitting the Change: ☐ **Power of Attorney / Legal Guardian** ☐ **Agency** **Name:** **Address:** **Phone #:** **Email:**			

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

Reporting a Setting/Program Change

Effective Date of Change:_____

Add further details in comment box above as needed. Be sure to submit all supporting documentation as well.

Current Program [From]:		**New Program [To]:**
☐ **Nursing Home |Facility/NPI:** ☐ PACE		☐ **Nursing Home |Facility/NPI:** ☐ PACE
☐ **HCBS** ☐ Agency-Based Core Community ☐ Personal Choice ☐ Shared Living ☐ PACE ☐ Katie Beckett		☐ **HCBS** ☐ Agency-Based Core Community ☐ Personal Choice ☐ Shared Living ☐ PACE ☐ Katie Beckett
☐ **Assisted Living | Facility/NPI:** ☐ **Tier Change Request**: From Tier_____		☐ **Assisted Living | Facility/NPI:** ☐ **Tier Change Request: To Tier_____**
☐ **BHDDH** ☐ Group Home ☐ Community	⟷	☐ **BHDDH** ☐ Group Home ☐ Community
☐ **Eleanor Slater Hospital**		☐ **Eleanor Slater Hospital**
☐ **FATIMA (LTBHU)**		☐ **FATIMA (LTBHU)**
☐ **Habilitation** ☐ Group Home ☐ Community		☐ **Habilitation** ☐ Group Home ☐ Community
☐ **Nursing Home Transition Program/MFP**		☐ **Nursing Home Transition Program/MFP**
☐ **Community Medicaid (Non-LTSS)**		☐ **Community Medicaid (Non-LTSS)**

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:_____