RI Department of Human Services

LTSS Change Communication Form

Process Name:	Directions for LTSS Change Form
Effective Date:	September 24, 2021
Audience:	DHS, Interagency Partners Agency, NH, Stakeholders

Purpose: The purpose of the LTSS Change Form is to facilitate the communication of changes to a customer's LTSS financial, program, setting and other demographic information. This will allow DHS to update the customer's LTSS record and eligibility to reflect their current status.

Process: Stakeholders, customers, interagency partners, attorneys, and Nursing Homes will complete the LTSS change form to indicate a change of program, setting, finances or demographics.

1. LTSS change form should include the customer's demographic information including name, DOB and or Social security number or Medicaid Identification number
2. LTSS change form should include Name and contact for the person submitting the document under "Power of Attorney/Referring Agency" to enable DHS staff to follow up with questions and get clarification on the change request.
3. LTSS change form should include supporting documentation
    a. Financial change-updated financial, income and resource information
    b. Program change/Setting change: updated medicals, PM1, DHS25, DHS25M, CP12, etc.
        i. For program changes, enter client's current program and new program
    c. Demographic change: supporting documentation to support the change-name, address, etc.
4. Please utilize comment section to provide additional clarifying information to facilitate DHS's staff ability to quickly process change request.
5. DHS should process change requests within 30 days of receipt. Once processed, DHS will send via fax or email the HCBS-2 turn-around form confirming the change and associated shares/COC, etc. A Benefit Decision Notice is also sent to the address on file reporting changes to the case.

LTSS Change Form

Instructions: Please complete this form to report all LTSS Changes. For all Program Changes **please submit a signed CP-12, DHS-25 and DHS-25M (medicals and assessment if applicable); *for Nursing Homes* please also submit PM-1, AP 70.1 and MA-PASSR.** Send all documents to: Long Term Support and Services P.O Box 8709 Cranston, RI 02920 or Fax:401-574-9915 or email DHS.LTSS@dhs.ri.gov. For additional questions, the LTSS Coverage Line is 401-574-8474.

Client's Information [*Fill out completely*]

Date: _____

Name:	D.O.B Case #:	SSN / MID (circle)
Address:		
Phone # / Alternate Phone #		Comment:
Power of Attorney or Referring Agency (circle)		
Power of Attorney / Referring Agency Name:		
Power of Attorney / Referring Agency Address:		
Power of Attorney / Referring Agency Telephone/ Email:		

Change / Status [*Check all that apply*]

○ **Medicaid to LTSS** *Be sure to attach completed Application*	○ **Financial / Resource Change** *Add details in comment box. Be sure to submit verification documentation*	○ **Program Change** *Add details in comment box.* Date:
○ **Admitted to Nursing Home** *Add details in the comment box*	○ **Money Follows the Person** Date:	○ **NH Transition** *Add details in the comment box* Date:
○ **Change of Address** *[(Provide new address) including an **Out of State Address***]		

○ **Closing** Date:	○ **Close: Deceased** Date:	○ **Close: Out of State** *Provide new address above* Date:	○ **Withdrawal** Date:

LTSS Currently Enrolled in: ☐ Client currently **does not** have LTSS Client has/had Neighborhood

HCBS ○ Preventive ○ DHS Core Community Date:	**Self-Directed Care** ○ Independent Provider ○ Personal Choice ○ Shared Living	**OHA** ○ OHA Core Community
Nursing Home Facility Name: Admission /Start Date: Discharge Date:	**Assisted Living** Facility Name: ○ OHA ○ RIH	Intended Start date: Room & Board $_____ Personal Needs Allowance$_____
○ **Eleanor Slater** ○ **FATIMA (LTBHU)**	**Habilitation** ○ Group Home ○ Community	**BHDDH** ○ Group Home ○ Community