MEDICAID FUNDED LONG-TERM SERVICES AND SUPPORTS (LTSS) AUTHORIZATION FORM

I. INDIVIDUAL INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Gender: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?

1 = Yes
2 = Not currently Medicaid eligible but anticipated to be financially eligible within 180 days of nursing facility admission
3 = Not currently Medicaid eligible, nor anticipated to be Financially eligible within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid?
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?

0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Department of Social Services:
(Eligibility Responsibility)_____
(Services Responsibility)_____

III. LTSS SCREENING INFORMATION: (to be completed only by authorized Medicaid or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care

1 = Nursing Facility (NF) Services
2 = PACE
4 = Commonwealth Coordinated Care (CCC) Plus Waiver

11 = ALF Residential Living * (see note below)
12 = ALF Regular Assisted Living * (see note below)

15 = Private Duty Nursing Services provided in the CCC Plus Waiver

Exceptions: Authorizations for NF, PACE, CCC Plus Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF. **NF = CCC Plus Waiver or PACE.**

NO MEDICAID SERVICES AUTHORIZED

8 = Other Services Recommended
9 = Active Treatment for MI, ID or RC
0 = No other services recommended

Targeted Case Management for ALF

0 = No 1 = Yes

ALF Reassessment Completed

1 = Full Reassessment 2 = Short Reassessment

ALF provider name: _____
ALF admit date: _____

SERVICE AVAILABILITY

1 = Individual on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, services to start immediately

Did the individual die after the Medicaid LTSS/ALF screening Authorization but before services were received?
1 = Yes 0 = No

LENGTH OF STAY (If approved for Nursing Facility)

1 = Temporary (less than 3 months)
2 = Temporary (less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between NF, PACE, or CCC Plus Waiver. The progress notes should be provided to the eligibility worker with the local departments of social services.

LTSS/ALF SCREENING IDENTIFICATION

Name of LTSS/ALF screener agency and provider number:

1._____

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2._____

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_____

LEVEL II ASSESSMENT DETERMINATION – FOR NF AUTHS ONLY – DOES NOT APPLY TO WAIVERS.

Name of Level II Screener and ID number who completed the Level II for a diagnosis of MI, ID, or RC.

1._____

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0 = Not referred for Level II assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NF

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the Individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this Individual.

_____ ___/___/_____
Medicaid LTSS/ALF Screener **Title** **Date**

_____ ___/___/_____
Medicaid LTSS/ALF Screener **Title** **Date**

_____ ___/___/_____
Medicaid LTSS Physician **Date**

Instructions for completing the *Medicaid Funded Long-Term Services and Supports Authorization* (DMAS-96)

I. Individual Information:

A. Enter Individual's Last Name. **Required**.

B. Enter Individual's First Name. **Required**.

C. Enter Individual's Birth Date in MM/DD/CCYY format. **Required**.

D. Enter Individual's Social Security Number. **Required**.

E. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have 12 digits.

F. Gender: Enter "F" if Individual is Female or "M" if Individual is Male. **Required**.

II. Medicaid Eligibility Information:

A. Is Individual Currently Medicaid Eligible?

- Enter a "1" in the box if the Individual is currently Medicaid eligible.
- Enter a "2" in the box if the Individual is not currently Medicaid eligible but anticipated to be financially eligible within 180 days after nursing facility.
- Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after nursing facility admission.

B. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or authorized representative has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term services and supports can be made regardless of whether the Individual has been determined Medicaid eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.

C. Is Individual currently Auxiliary Grant eligible? Enter appropriate code ("0", "1", or "2") in the box.

D. Local Depts. of Social Services: The local departments of social services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.

III. Medicaid LTSS Screening Information:

A. Medicaid Authorization: Enter the numeric code that corresponds to the Medicaid LTSS Screening Level of Care (LOC) authorized. Enter only one code in this box. **Required**.

1	**Nursing Facility (NF)**	Authorize only if Individual meets the NF LOC criteria.
2	**PACE**	Authorize only if Individual meets NF LOC criteria and requires a community-based service to prevent institutionalization.
4	**Commonwealth Coordinated Care Plus Waiver**	Authorize only if Individual meets NF LOC criteria and requires a community-based service to prevent institutionalization.
11	**ALF Residential Living**	Authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration
12	**ALF Regular Assisted Living**	Authorize only if Individual has dependency in either 2 ADLs or behavior.
15	**Private Duty Nursing Services in CCC Plus Waiver**	Authorize only if the Individual meets NF LOC criteria and/or has extensive medical/nursing needs and requires a community-based service to prevent institutionalization.

Exceptions: Authorizations for NF, PACE, or CCC Plus Waiver are interchangeable. Screening updates are not required for Individuals to move between these services because the alternate institutional placement is a NF. **NF = CCC Plus Waiver or PACE.**

Instructions for completing the *Medicaid Funded Long-Term Services and Supports Authorization* (DMAS-96)

B. No Medicaid Services Authorized:

8	**Other Services Recommended**	Includes informal social support systems or any service excluding Medicaid-funded long term services and supports such as companion services, meals on wheels, ID/DD or Day Support waivers, rehab services, etc.).
9	**Active Treatment for MI/ID or Related Condition**	Applies to those Individuals who meet NF criteria but require active treatment for a condition of mental illness or intellectual/developmental disabilities and cannot appropriately receive such treatment in a NF.
0	**No Other Services Recommended**	Use when the screening team recommends no services or the Individual refuses services.

C. Targeted Case Management for ALF: If ALF services are authorized; you must indicate whether Targeted Case Management for ALF (quarterly visit) is also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services.
ALF Targeted Case Management Services includes the annual reassessment.

D. ALF Reassessment: Mark the appropriate code for the long reassessment ("1") or a short reassessment ("2").

E. ALF Provider Name: Enter the name of the ALF in which the Individual entered. Otherwise leave blank.

F. ALF Admit Date: Enter the date the Individual entered an ALF. Otherwise leave blank.

G. Service Availability: If a Medicaid-funded long term services and supports is authorized, indicate whether there is a waiting list ("1") or that there is no provider ("2"), or whether the service can be started immediately ("3").

H. Length of Stay: If approval of NF services is made, please indicate how it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between NF, PACE or the CCC Plus Waiver. The progress notes should be provided to the eligibility workers with the local departments of social services.

I. Medicaid LTSS/ALF Screening Identification: Enter the name of the screening agency or facility (for example, hospital, local DSS, local health department, Area Agency on Aging, State MH/IDD facility, CIL) and below it, in the 10 boxes provided, that entity's 10 digit NPI/API number.
For Medicaid to make prompt payments to LTSS Screening Teams, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*
If the LTSS Screening is completed in the locality, there should be two screeners, from both the local DSS and local health departments. Otherwise, there will be only one screener identification entered.

J. Level II Assessment Determination: If a Level II assessment was performed (MI, IDD or Related Condition), enter the name of the screener on the top line and below it, in the 10 boxes provided, that entity's 10 digit NPI/API number. Level II assessments apply to NF authorizations ONLY.
Enter the appropriate code in the box.

K. When a Screening Team is aware that an Individual has expired prior to receiving the services authorized by the screening team, a "1" should be entered in this box.

L. The Medicaid LTSS/ALF Screener must sign and date the form. **Required.**

M. The Medicaid LTSS/ALF Screener must sign and date the form. **Required for all services except ALF placement.**

N. The Medicaid LTSS physician must sign and date the form. **Required for all services except ALF placement. Physician signature and date is the last item to be completed on this form. Physician must sign and date for himself or herself; others may not sign/date for the physician.**

IV. Final Items:

A. Once the Medicaid LTSS Screening has been completed, the Screening Team should supply a copy of the Screening Package to the Individual, and the Individual's provider of choice if the individual is FFS. If the Individual is a CCC Plus member, the Screening Package should be sent to the appropriate Health Plan Care Coordinator.

B. For adults, the Screening Team must maintain a complete copy of the Medicaid LTSS Screening in their files for a period of not less than 6 years from the date of screening. For children, Screening teams must retain documents for at least six (6) years after such minors have reached 21 years of age. Files may be in either paper or electronic format.

*NOTE: DMAS does not require the submission of ALF Screening documents. Screening Teams are required to follow all regulations with respect to completion of the documents for ALF services. The Screening Teams should follow instructions provided regarding reimbursement for ALF screenings.