Financial Communication to Social Services.
Barcode DSHS form 07-104

Purpose: Communication between the HCS or DDA / LTSS Public Benefit Specialist (PBS) and HCS / AAA / DDA social worker (SW) / case manager (CM) is an important piece for correct long-term services and supports (LTSS) eligibility. Initial eligibility for LTSS is done concurrently by both the PBS and the SW/CM. Changes in circumstance must be communicated back and forth between the PBS and SW / CM to maintain correct eligibility.

LTSS has 2 parts to eligibility:

1. The financial eligibility for the medical program; and
2. The functional eligibility for the service.

In addition, there are two (2) start dates for Medicaid:

1. The Medicaid start date is always the first day of the month unless there is a transfer penalty, and the client is not eligible for any other Medicaid program except institutional or HCBS Waiver.
2. The service start date. This is the date LTSS starts.
3. For NF admissions:
   a. For applicants the earliest of the following:
   b. The first day of the month the client is eligible up to 3 months prior to the date of application. If there is a transfer of asset, it is the day following the end of the transfer period; or
   c. The date of admission to the facility. If there is a transfer of asset, it is the day following the end of the transfer period; or
      i. For recipients, the first day DSHS was notified of the admission; and
      ii. The client is NFLOC
4. For HCB waivers, the service start date is when the SW/CM started the service and the client is found financially eligible. This date is provided to the PBS by the SW/CM via the 15-345 (DDA) or the 14-443 (HCS). If the case was fast-tracked and the client was not financially eligible, notify the SW/CM.
5. Nursing facility level of care (NFLOC) determination is needed when the applicant is applying for HCBS Waiver and there is a transfer penalty that needs to be established.

Mandatory points in Financial Application Process (when to send 07-104 to Social Services)

- **After the first attempted contact with the client / representative, even if interview was not completed.** This step is where you want to provide as much information to Case Management regarding the client's current circumstances.
- **When the client / representative has provided us with the requested verifications or has not provided verifications by the due date.** Leave comment for when: extension is requested; application denied into 30-day reconsideration; or client needs help gathering documents (reference the request letter)
- **When financial eligibility has been determined.** Address: transfer penalties, if client over resources, or date client will be financially eligible.
- **If services have not been approved by the SW / CM at the end of application time period.** Send 07-104 regarding LTSS denial and determine if there is eligibility for any other medical programs.

Instructions

1. **PBS and client information:** The barcode 07-104 auto-populates the date, PBS name, telephone number, organization, (HCS / AAA case managers or DDA), ACES ID and client address in the appropriate fields.
2. **Case Information:**
   a. Indicate if the client is on Medicare. This is needed so the SW / CM knows whether HCBS waiver services may be needed to waive Medicare D co-payments.
   b. Indicate equal access / NSA needs. NSA examples are:
      i. Large print for clients with impaired vision.
      ii. Case management assistance is needed for forms or verification. Be clear what type of case management assistance is needed for the client to retain or achieve medical eligibility.
      iii. Assistance in applying for certain benefits that is required for Medicaid eligibility such as Medicare.
   c. LEP indicated in ACES is pre-populated.
   d. Application status information. Information on initial application status is indicated in these fields.
   e. DDA expenses for room and board. These fields are used by the DDA LTC and specialty programs unit regarding expenses that need an ETR decision by the DDA case manager.
3. **Representative:** Complete information on the client's representative.

4. **Service Request:**
    a. Indicate if NFLOC determination is needed
    b. Nursing home
        i. For recipients, the PBS needs the date SW/CM or intake was notified of the admission
        ii. Review for home maintenance allowance. If approved all clients get the FPL amount, no actual amount needed.
    c. TSOA: Check this box if the client is applying for TSOA.
    d. MAC: Check this box if the client is applying for MAC
    e. MPC / CFC Check this box if the client is applying for MPC / CFC and indicate the living arrangement (in home or residential).
    f. HCBS waiver: Check this box if the client is requesting HCBS Waiver
    g. Ongoing Additional Requirements (OAR). Indicate type of OAR in comments
    h. Non-grant medical assistance packet is needed to be sent to DDDS for a disability determination.
    i. State funded services.
        i. LTSS for non-citizens, pre-approval from HCS HQ is required. Check the box for in-home or residential
        ii. Medical Care Services (MCS). Must be eligible for HEN/ABD cash. Check the box for nursing facility or residential.
    j. Fast Track (HCS only):
        i. Check the box if the client appears to be financially eligible and a good candidate to fast-track services. (See Fast Track Guideline for help)
        ii. If the client is not a good candidate for fast-track, check the box and briefly explain why (examples include: when the client appears over resources; transfers that may cause a penalty period; or information provided is not enough to determine if the client appears financially eligible).
        iii. Select the programs fast track can be utilized for.
    k. R2 HCS ABD cash/HEN/MCS and ESH/WSH, use For HCS USE ONLY section to indicate the request for those that have designated state as it will facilitate an automatic assignment through the MATRIX.
5. **Financial eligibility determination:** Check the appropriate box for the Medicaid program, MAC or TSOA the client is financially eligible for.
    a. Enter a projected date of financial eligibility if you have determined the client to be eligible in a future month (this is helpful for private pay to Medicaid cases). Example: client applies on 06/25/2021 and has been paying private in an adult family home. The client has enough money to pay privately for 07/2021 but expects to be at or below the resource standard on 08/01/21. In this example indicate 08/1/2021 as the projected financial eligibility and indicate in the comments it is a private pay to Medicaid request.
    b. Client responsibility: Indicate the estimated amount of participation based on information on the application and/or interview for the first three (3) months. This field is only completed for initial / pending applications.
6. **Comments.** Add additional comments that need to be communicated to the SW / CM. For example, the client needs help gathering documents or you have been unable to contact the client for an interview.
7. **Client responsibility overpayment / underpayment.** This is used to notify the SW/ CM of historical changes in participation liability based on Method 3.
    a. Reason. Enter the reason why client responsibility has changed: Increase in income, decrease in income, increase in allowable deductions, or decrease in allowable deductions.
    b. Enter whether it is client or department caused.
    c. If it is client caused, enter whether the change was reported timely.
    d. In the table enter the correct month / year; previous client responsibility (what is in ACES); correct client responsibility (what **should be** in ACES); and the amount of the overpayment / underpayment.