STATE OF HAWAII
Department of Human Services

Med-QUEST Division

# MEDICAID ELIGIBILITY FOR LONG-TERM CARE (LTC) SERVICES

## SECTION 1: AUTHORIZED MEDICAID PROVIDER AND MED-QUEST DIVISION

**TO:** **Med-QUEST Eligibility Branch** Contact Name: Sent Date:

Phone No. Fax No. Email Address:

***FROM:** ☐ Med-QUEST Health Plan ☐ Case Management Agency (CMA)
☐ Nursing Home/Intermediate Care (ICF-ID) Facility/Hospital WL ☐ DDD Case Manager

Contact Name: Email Address:

Phone No. Fax No.

## SECTION 2: APPLICANT/BENEFICIARY INFORMATION

Applicant/Beneficiary Name (last, first, M.I) CLIENT ID No. /last 4 digits of SSN Date of Birth

Case Name (if different from Applicant/Beneficiary) Phone No. Email Address

Marital Status: Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Married ☐ Spouse Name: _____

## SECTION 3: NEW ADMISSION OF LONG-TERM CARE (LTC) SERVICES REQUEST

Approved Level of Care (LOC) ☐ DHS 1147 ☐ DHS 1150 (CSO) ☐ DHS1150C (CSO) Start/End Date:

### ☐ A. Nursing Home Placement (NH)

Facility/Address: Phone No. Date of Admission ☐ Revised

### ☐ B. Hospital Waitlisted Placement (WL)

Hospital/Address: Phone No. Date of Admission ☐ Revised

### ☐ C. Home and Community Based Services Placement in a Private Home (HCBS) Code: 299

Physical Address Phone No. Date of Admission

### ☐ D. Community Care Foster Family Home (HCBS) Code 299 *CMA ONLY

Caregiver Name Date of Admission ☐ Revised

Physical Address Phone No.

☐ Assisted Living Facility (ALF) ☐ D1 (Dom. Level I, CCFFH or EARCH) ☐ D2 (Dom. Level II, EARCH only)

Caregiver Name Date of Admission ☐ Revised

Physical Address Phone No.

### ☐ E. Going Home Plus (Codes-Check one) ☐ Aged (131) ☐ Disabled (132) ☐ I/DD (403) *

**Living Setting:** ☐ HO (Private Home) ☐ Assisted Living Facility (ALF) ☐ D1 (Dom. Level I, CCFFH, EARCH, DD DOM, DD AFH)

Caregiver Name Date of Admission ☐ Revised

Physical Address Phone No.

### ☐ F. Intellectual/Developmental Disability Waiver (I/DD) Code: 404 DDD Case Manager ONLY

**Living Setting**: ☐ HO (Private Home) ☐ D1 (Dom. Level I, DD Dom, DD-AFH, E/ARCH) ☐ D2 (Dom. Level II, E/ARCH)

Caregiver Name Date of Admission ☐ Revised ☐ Pending Medicaid

Physical Address Phone No.

☐ DHS 1150C attached ☐ ADRC 1180 attached (as needed) ☐ Medical Expenses Worksheet (attached as needed)

### ☐ G. Intermediate Care Facility-I/DD Placement (ICF-I/DD)

Facility/Address: Phone No. Date of Admission ☐ Revised

☐ DHS 1150 attached ☐ ADRC 1180 attached (as needed)

## SECTION 4: EXISTING LTC BENEFICIARY CHANGE REQUEST *

☐ Beneficiary no longer eligible for LTC Effective Date ☐ NO LOC ☐ Date of Death ☐ Other Reason:

☐ Beneficiary changed residence Effective Date Phone No.

New Physical Address

**TO: Living Setting** ☐ HO (Private Home) ☐ Assisted Living Facility ☐ Nursing Facility ☐ ICF/ID Facility
☐ D1 (Domiciliary Level I, DD Dom, DD-AFH, E/ARCH, CCFFH) ☐ D2 (Domiciliary Level II, E/ARCH)

**New** Caregiver Name and Physical Address

☐ Other/Comments:

## SECTION 5: LTC ELIGIBILITY DETERMINATION (completed by MQD) **Medicaid Approval Date:**

LTC Services Effective Date(s) _____ ☐ Denied/Date_____ ☐ Terminated/Date_____

**Denial Reason:** ☐ Excess Assets/Resources ☐ Transfer of Assets ☐ Excess Property ☐ No LOC ☐ Failure to Provide

☐ Other/Comments:

☐ Change does not affect Medicaid eligibility ☐ No Cost Share ☐ Cost Share $_____

☐ Spousal/Dependent Contribution Applied $_____

| MQD Eligibility Staff (Print Name and Signature) | Response Date |
|---|---|
| | |