MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

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

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
- 1 = Yes
- 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
- 3 = Not currently Medicaid eligible, not anticipated 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

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care ☐
- 1 = Nursing Facility (NF) Services
- 2 = PACE
- 3 = AIDS/HIV Waiver Services
- 4 = Elderly or Disabled w/Consumer Direction (EDCD) Waiver
- 11 = ALF Residential Living
- 12 = ALF Regular Assisted Living
- 14 = Individual/Family Developmental Disabilities Waiver
- 15 = Technology Assisted Waiver
- 16 = Alzheimer's Assisted Living Waiver

Exceptions: Authorizations for NF, PACE, AIDS or the EDCD Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF. **NF = EDCD, AIDS, or PACE**
Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the NF criteria. **NF = Alzheimer's ALF**

NO MEDICAID SERVICES AUTHORIZED
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/MR Condition
- 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 provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY ☐
- 1 = Client on waiting list for service authorized
- 2 = Desired service provider not available
- 3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home) ☐
- 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 Nursing Facility, PACE, HIV/AIDS waiver and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION
Name of Level I/ALF screener agency and provider number:

1._____

☐☐☐☐☐☐☐☐☐☐

2._____

☐☐☐☐☐☐☐☐☐☐

LEVEL II ASSESSMENT DETERMINATION – FOR NF AUTHS ONLY – DOES NOT APPLY TO WAIVERS.
Name of Level II Screener and ID number who have completed the Level II for a diagnosis of MI, MR/ID, or RC.

1._____

☐☐☐☐☐☐☐☐☐☐

- 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 NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

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 recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form* (DMAS-96)

- Enter Individual's Last Name. **Required.**
- Enter Individual's First Name. **Required.**
- Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
- Enter Individual's Social Security Number. **Required.**
- Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have twelve digits.
- Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
- 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 it is anticipated that private funds will be depleted within 180 days after Nursing Facility admission or within 45 days of application or when waiver services begin.

  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.
- If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care 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.
- Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
- Dept of Social Services: The 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.
- Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box. **Required.**

Exceptions: Authorizations for NF, PACE, AIDS or the EDCD Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF. **NF = EDCD, AIDS, or PACE** Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF; however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify. **NF = Alzheimer's ALF**

1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

2 = **PACE** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).

4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF 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.

14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

15 = **Technology Assisted Waiver** authorize only if the Individual meets the criteria for admission criteria to a NF level of care; has extensive medical/nursing needs and requires a community-based service to prevent institutionalization.

16 = **Alzheimer's Assisted Living Waiver** authorization only if the Individual meets the criteria for admission to a NF and requires a community-based service to prevent NF institutionalization. Authorize only if the individual has a medical diagnosis of Alzheimer's disease. ***If ALF is authorized***, enter, if known, the provider name and provider number of the ALF that will admit the Individual. Enter, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.

- Targeted Case Management for ALF: If ALF services are ***authorized***; you must indicate whether Targeted Case Management for ALF (quarterly visits) 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.
- ALF Reassessment: Mark the appropriate code for a long reassessment = 1 or a short reassessment = 2.
- ALF Provider Name: Enter the name of the ALF in which the Individual was placed. Otherwise leave blank.
- ALF Provider Number: Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank.
- ALF Admit Date: Enter the date the Individual entered an ALF. Otherwise leave blank.
- Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
- Length of Stay If approval of Nursing Facility care is made, please indicate how long 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 Nursing Facility, PACE, HIV/AIDS Waiver or the EDCD Waiver. The progress notes should be provided to the local departments of social services Eligibility workers.
- Level I/ALF Screening Identification Enter the name of the Level I screening agency or facility (for example, Hospital, local DSS, local Health, Area Agency on Aging, CSB, State MH/MR 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 Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*
- If the Pre-Admission Screening is completed in the locality, there should be two Level I screeners, both the local DSS and local Health departments. Otherwise, there will only be one Level I screener identification entered.
- Level II Assessment Determination If a Level II assessment was performed (MI, MR/ID or Dual), enter the name of the assessor 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 nursing facility authorizations **ONLY**.
- Enter the appropriate code in the box.
- When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
- The Level I/ALF Screener must sign and date the form. **Required.**
- The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement, which does not include Alzheimer's Assisted Living Waiver.**
- The Level I 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 him/herself; others may not sign/date for the physician.**
- Once the pre-admission screening has been completed, the screening team should supply a copy to the recipient's provider of choice.
- The screening team must maintain a complete copy of the pre-admission screening in their files for a period of not less than 5 years from the date of the screening. Files may be in either paper or electronic format.

DMAS-96 Instructions (revised 02/09)