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| Transforming Lives.png | HOME AND COMMUNITY SERVICES (HCS)AREA AGENCIES ON AGING (AAA)DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)**Financial Communication to Social Services** |  |
| DATE |
| FROM: NAME | PHONE NUMBER | ORGANIZATION |
| 1. **Client Information**
 |
| CASE NAME | PHONE NUMBER | MESSAGE NUMBER | ACES ID |
| ADDRESS CITY STATE ZIP CODE |
| 1. **Case Information**
 |
| [ ]  Equal Access (NSA) Accommodation Plan:  | [ ]  Medicare eligible (has or will have Part D co-pays) |
| [ ]  Limited English Proficiency preferred language:  | Civil Transitions Program Start Date(conditionally eligible): [ ]  Yes  |
| Application date:  [ ]  Approved [ ]  Withdrawn [ ]  Active Medicaid [ ]  Active TSOA [ ]  Denied [ ]  Pending [ ]  Over resources [ ]  Functional eligibility determination [ ]  Asset transfer penalty period:  to  [ ]  Verification due date:   [ ]  Other   |
| EXPENSES **(FOR DDA USE ONLY)**[ ]  Court ordered fees: Guardian $ ; Attorney $ [ ]  Medical $ [ ]  DDA Room and Board ETR Request (CRM, please approve or deny on 15-345). Total ETR amount $ COMMENTS:  |
| 1. **Representative**
 |
| NAME | REPRESENTATIVE TYPE[ ]  Authorized representative[ ]  Attorney-in-fact [ ]  Legal guardian[ ]  Representative payee[ ]  Parent / Spouse |
| ADDRESS CITY STATE ZIP CODE |
| PHONE NUMBER (AREA CODE) | EMAIL ADDRESS |
| 1. **Service Request**
 |
| Meets NFLOC? [ ]  Yes [ ]  No[ ]  Nursing Facility [ ]  Home Maintenance Allowance [ ]  TSOA [ ]  MAC [ ]  MPC / CFC [ ]  In-home [ ]  Residential[ ]  HCS / DDA HCB Waiver [ ]  In-home [ ]  Residential [ ]  Ongoing Additional Requirements (indicate type of OAR in comments)[ ]  Non-grant Medical Assistance (NGMA) packet is needed for disability determination**State Funded Services**[ ]  LTC for non-citizens (preapproval needed) [ ]  In-home [ ]  Residential [ ]  NF [ ]  MCS residential [ ]  MCS NF | **For HCS Use ONLY****This section is only for referrals to designated WSH / ESH and NGMA / Incapacity / SSI facilitation social workers.**[ ]  **ABD case disability / HEN incapacity determination**[ ]  **SSI Facilitation**[ ]  **WSH / ESH**[ ]  **Other (indicate specific request in comments)**  |
| [ ]  Client is a good candidate for Fast Track? [ ]  Yes [ ]  No, and why not?  Potentially eligible for: [ ]  MPC [ ]  CFC [ ]  Waiver [ ]  Other  |
| 1. **Financial Eligibility Determination**
 |
| [ ]  Financially eligible for CN (MPC or CFC)[ ]  Financially eligible for CN (CFC, but not financially eligible for MPC)[ ]  Financially eligible for CN (MAC)[ ]  Financially eligible for HCBS waiver [ ]  HCBS waiver rules are needed for eligibility (not eligible for CFC only)[ ]  Financially eligible for MCS (state-funded residential / NF (A01/A05)[ ]  Financially eligible for LTSS for non-citizens (L04 / L24) [ ]  Financially eligible for TSOA | PROJECTED DATE OF FINANCIAL ELIGIBILITY |
| ESTIMATED AMOUNT OF CLIENT RESPONSIBILITY |
| MONTH 1 | MONTH 2 | MONTH 3 |
| **$** | **$** | **$** |
| 1. **Comments**
 |
|  |
| 1. **Client Responsibility Overpayment / Underpayment**
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| **Overpayment / Underpayment (client reimbursement) notification. WAC reference:** Chapter 182-515 WAC, WAC 182-513-1315, WAC 182-504-0100, WAC 182-504-0105, WAC 182-504-0120 |
| REASON FOR OVERPAYMENT / UNDERPAYMENT | CLIENT OR DEPARTMENT CAUSED?[ ]  Client [ ]  Department | CHANGE REPORTED TIMELY?[ ]  Yes [ ]  No |
| MONTH / YEAR | PREVIOUS CLIENT RESPONSIBILITY | CORRECT CLIENT RESPONSIBILITY | OVERPAYMENT / UNDERPAYMENT AMOUNT |
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