



APPLE HEALTH (MEDICAID) MANUAL REVISION

Revision #	033
Chapter / Section	Long term services and supports (LTSS)/ Applications for long term services and supports (LTSS)
Issued Date	1/1/2018
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Summary of Revision

<https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/applications-long-term-services-and-supports>

- Updated Region 1 social service intake information
- Added Tailored Supports for Older Adults (TSOA)
- Added information about Hospice
- Added TSOA HCA 18-008 application
- Added best practice guidelines for fast track

Apple Health (Medicaid) Manual revision via track changes:

<http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/applications-ltc>

Applications for Long term services and

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supports (LTSS)

Revised 1/1/2018

Purpose: This section describes the application processes used by Aging and Long-term Supports Administration (AL TSA) when determining financial eligibility for LTSS.

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How to Apply

(WAC in the box 182-503-0005 is here)

Clarifying Information

What is the best way to apply for Long-Term Care services?

Applications may be submitted using any of the following methods:

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- Apply online at: www.WashingtonConnection.org
if the client applies using the Washington Connection website the application will be assigned to a Home & Community Services office. This is not a real-time eligibility process.
- Apply online at www.wahealthplanfinder.org.
 - Applications submitted through this site will have a real-time determination of Washington Apple Health medical coverage eligibility under the modified adjusted gross income (MAGI) methodology. If a client is 65 or over or on medicare, their eligibility is not done in real time and they will be redirected to the WashingtonConnection.org link to complete the application process.
 - To apply for LTSS through this site, the client must indicate a need for LTSS in the Additional Questions screen in the Healthplanfinder application AND take the link at the end of the application to transfer the application data to the Washington Connection site to complete additional information that is needed specific to LTSS.

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- Apply by completing the [HCA 18-005](#) Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled coverage and mail or FAX into HCS [1-855-635-8305](#); or
- Apply by completing the [HCA 18-008](#) Washington Apple Health for Tailored Supports for Older Adults (TSOA), which is a program that helps caregivers who are caring for a family member.
- Apply in-person at a local Home & Community Services office. To find an HCS office near you, check at www.altsa.dshs.wa.gov/Resources/clickmap.htm.
- Call the HCS intake line in the area in which you reside to schedule an assessment. See "How to request an LTSS assessment".

Mailing or Faxing Documents to Home and Community Services (HCS)

Mail to:

Home and Community Services - LTSS Services
 PO Box 45826
 Olympia WA 98504-5826; or FAX to: 1-855-635-8305

Always include the full case name and the DSHS client ID (if known) on any document mailed or FAXED to DSHS.

What if the applicant for LTSS is already on Washington Apple Health?

1. A new application is not required for clients active on [Aged, Blind, Disabled \(ABD\)](#) medicaid who need LTSS, as long as the financial worker is able to determine institutional eligibility using information in the current case record. Examples of [ABD](#) medicaid programs are the SSI or SSI-related programs or Healthcare for Workers with Disabilities ([HWD](#)). Use the original eligibility review date to open institutional coverage. [This includes the S99 spenddown program and a request for HCB Waiver or TSOA. CMS requires an annual review at least once a year for medicaid.](#)
2. Review excess home equity, annuity, and transfer of resource provisions that are specific to institutional and home and community-based waivers.
3. SSI recipients who need institutional services must complete and sign [and application or](#) the [DSHS 14-416](#) Eligibility Review for Long-Term Care Benefits (<http://www.dshs.wa.gov/forms/eforms.shtml>) in order to review home equity, annuity, and transfer of resource provisions. Do not hold up eligibility for long-

Deleted: <#>Long-term care applications for parents and children must be submitted through the Washington Healthplanfinder site. Hospitals and agencies applying on behalf of a child or parent for the (K01) program should also send a follow up email to K01Applications@dshs.wa.gov.

Commented [RL(1)]: <https://www.hca.wa.gov/assets/free-or-low-cost/18-008.pdf> link to the form.

Deleted: <#>Note: All the questions needed for Aged, Blind, Disabled Washington Apple Health including long-term care services have been incorporated in the Washington Connections online application. This is an electronic version of the DSHS 14-001 with added questions for Aged, Blind, Disabled medical and long-term care. (The paper version of the DSHS 14-001 is used only for cash and food).

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term care awaiting a signed review. If an application, review or LTSS review is in the electronic case record within that past year, a new review form is not needed.

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LTSS Applications for clients on MAGI-based Washington Apple Health

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A client that is active on Modified Adjusted Gross Income (MAGI) medical (N track in ACES, with the exception of AEM N21 and N25), needing nursing facility services, Community First Choice (CFC), or Medicaid Personal Care (MPC) don't need to submit an application. MAGI medical coverage is determined through the Health Benefit Exchange (HBE), not DSHS; and includes nursing facility care, CFC, and MPC within the benefit package for those functionally eligible for the service. If the client needs services that can only be provided through one of the home and community-based (HCB) waiver programs, the client must submit the HCA 18-005 application form so a resource determination can be made. In addition, the client will need to determined disabled or blind through the Division of Disability Determination services (DDDS), if disability/blindness has not already been established. A nursing facility award letter is not issued by the HBE. Nursing facilities must coordinate payment for MAGI clients with the client's managed care plan (if enrolled at the time of admission) and bill HCA directly for any custodial services provided once payment under the Managed Care Organization (MCO) has ended.

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Clarifying information

Financial workers will complete a referral using the 07-104 to social services when an application is received on an active MAGI case. Add text that unless an assessment is completed and determines HCB Waiver is needed, financial will not pursue the application. Financial will send a general correspondence letter to the client indicating the application was received and since the client is currently receiving Medicaid services, additional information is not needed unless the assessment indicates HCB waiver is needed.

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NOTE: If an 18-005 is received on an active MAGI case and the client is in a NF or Hospice care center, no action is needed by financial. MAGI covers NF and Hospice under the scope of care. Mark all assignments no action needed. Exception is N21/N25 AEM MAGI. There is an issue in barcode when creating a 07-104 indicating this form cannot be processed on active MAGI cases. The following work around can be used. Instead of printing centrally, staff can print the form locally by selecting 'Yes'. The form prints locally and saves a copy to the ECR; the worker can find the form in the ECR and either manually set a tickle or document assignment.

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Example: Active MAGI client submits an application for LTSS (18-005) in the community and in need of an assessment. An active MAGI client is financially eligible for CFC or MPC depending on their functional assessment. The 18-005 for LTSS is not needed for this client if their needs can be met under CFC or MPC. Financial will complete the 07-104 and add the following text to social services/case manager. Financial will not pursue HCB Waiver eligibility because the client is an active MAGI case unless notified to do so by the SW/CM. In order for financial to pursue HCB Waiver services, Social Services will need to do a NGMA referral to DDDS because disability is not required for MAGI Medicaid. A NGMA referral is not needed for MAGI clients receiving social security disability. If HCB Waiver services are not needed, the client will remain on the MAGI program and the financial worker will not need to be notified when CFC or MPC services are opened. The financial MAGI case will remain with HBE/HCA. Note: Mark the 18-005 application no action needed. The exception is N21/N25 AEM because it does not cover LTSS.

Other Useful Information

The following links have additional information about applying for LTSS programs, Estate Recovery requirements and applying online through Washington Connection:

- [LTC overview gives a description of LTC services and program responsibilities for medical programs](#)
- [How to apply for LTC Medicaid through Home and Community Services](#)
- [Information about Medicaid and Estate Recovery](#)
- [When should one file an application for long-term care coverage?](#)

How to request a LTSS assessment

Call and request an assessment through the HCS central intake lines. The social service central intake lines are divided by Regions. The central intake lines are used to request a social service assessment for home and community services (in-home care, care in a residential facility, nursing facility coverage).

- Region 1 HCS-Pend Oreille, Stevens, Ferry Okanogan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams, Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin and Whitman: 1-509-568-3767 or 1-866-323-9409 or FAX 509-568-3772

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- [Region 2 North HCS - Snohomish, Whatcom, Skagit, Island Counties 1-800-780-7094 or FAX 425-977-6579](#)
- Region 2 South HCS - King County 206-341-7750 or FAX 206-373-6855
- Region 3 HCS- Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson Counties 1-800-786-3799 [or](#), FAX 1-855-635-8305

Deleted: <#>Region 1 South HCS-Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin. Contact the local Home and Community Service (HCS) office based on county: 1-509-568-3767 or FAX 509-575-2286

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[WAC 182-503-0010 Washington apple health -- Who can apply.](#)

[WAC 182-503-0040 Washington apple health -- Interview requirements.](#)

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Clarifying Information

There is no interview requirement for Washington Apple Health coverage unless information is missing from the application or the department needs more information. However, an interview is required to determine eligibility for institutional or HCB Waiver services. The interview may be held with the applicant or their authorized representative. [The interview can be face to face or by phone.](#) If the client is unable to complete the interview due to a medical condition or because [no one](#) is available to assist the client complete the application, then the FSS may waive the interview requirement and document why the interview was waived.

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Use [NSA](#) policies for long-term care applicants and recipients.

Worker Responsibilities

The interview can be conducted in person or by phone. If the client or representative can't be reached by phone, send a letter of request for what is needed based only on what was declared and ask the person to call you and arrange the interview.

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The financial worker must:

1. Go over the application, particularly what was declared in the income and resource sections. Ask about other resources not declared on the application. General open-ended questions about resources and income should also be asked. Family members and other representatives are often just learning about the client's income and resources when they apply. Open-ended questions often reveal that additional sources of income and assets may exist.

2. Ask about any transfers, gifts, or property sales during the [5-year](#) look back period and the circumstances of why they were made.

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3. Ask about other medical coverage. If there is other medical coverage and you can obtain the information during the interview, complete a [14-194 medical coverage form](#) and send to the HIU. Otherwise, send the form to the client for them to complete and return.

4. Ask if there are unpaid medical expenses and request verification if medical expenses exist. Ask if any of these bills were within the last 3 months.

5. Explain the financial and social service functional eligibility process. Explain to the applicant that there is a financial worker and a social worker making determinations concurrently for long term care eligibility.

6. For in home service applicants, discuss the food assistance program and inquire if the individual would like [food benefits](#).

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7. Explain the medical service card, automatic Medicare D enrollment if not on a creditable coverage or Medicare D PDP plan.

8. Explain the medicare savings program (MSP). If the applicant is eligible for a MSP program based on MSP income and resource guidelines and all information is received to determine eligibility for MSP, do not hold up processing this program while the [LTSS](#), medical is still pending.

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9. Explain what participation and room and board is, how the amount is determined and that it must be paid to the provider.

10. Explain what Estate Recovery is and mail the Estate Recovery fact sheet if the applicant has not received one.

11. Explain what changes of circumstances need to be reported

12. In the case of the community spouse, explain how all resources in excess of the \$2,000 resource limit must be transferred to the spouse within 1 year and [the requirement](#) to provide verification of this by the first annual review.

13. Explain what proof is needed to complete the application and that a follow-up letter will be sent listing what they are. Encourage the applicant to begin gathering required documents as soon as possible in order to expedite the application. Explain how to request an extension if more time is needed.

Document the interview in the ACES case.

Documentation reflects:

- Statements made by the client or their representative
- Eligibility decisions made and actions taken on the case; and
- Why the actions were taken

Documentation provides:

- An ongoing permanent history of actions and decisions taken;
- A support of eligibility, ineligibility and benefit determination;
- Credibility for decisions when used as evidence in legal matters;
- A trail for reviewers to determine the accuracy of the benefits issued

Follow these principles when documenting:

- Clear. Use readily understood language.
- Concise. Documentation is subject to public review. Stick to the facts relevant to determining eligibility or benefit level.
- Complete. The documentation must support the eligibility decision and allow a reviewer to determine what was done and why.
- Consistent. Explain how conflicts or inconsistencies of information were resolved. Demonstrate the reasonableness of decisions. Ensure what you document accurately describes what happened with the case.

[WAC 182-503-0060 Washington apple health \(WAH\)-- Application processing times](#)

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Clarifying Information

Documenting Standard of Promptness for all Medical Applications that are pending for 45 days or more

- "NG" or no delayed reason code will show up on the 45 data list to the DSHS Secretary
- A good cause code must be used when opening any medical assistance unit (MAU) historically beyond a 45 day time frame including program changes

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- A good cause code must be used when doing a program change from one medical program to another to prevent the case from showing up as a new application. If good cause is not indicated, a program change will show up as a new application.
- Day 1 is the day after the date the application was received

WAC 182-503-0070 Washington apple health (WAH)-- When coverage begins.

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Clarifying Information

There are two start dates for long term care services, the medicaid eligibility date and the LTSS start date:

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1. The date medicaid eligibility begins, which is always backdated to the first day of the month the individual is eligible for LTSS.
2. The LTSS start date (also called the authorization date) is described in WAC [388-106-0045](#) and [RCW 74.42.056](#). If there is a transfer penalty as described in WAC [182-513-1363](#), the LTSS start date begins the day after the transfer penalty ends.
3. The LTSS start date can't be backdated for HCB Waiver services. Social services indicates the start date for HCB Waiver on the DSHS 14-443 (communication from social services to HCS financial), or the DSHS 15-345 (communication from DDA case manager to financial).
4. For Hospice as a medicaid program, the hospice authorization date is based on the receipt of the 13-746 HCA/Medicaid Hospice Notification. It is required that the hospice provider submits this form within 5 days of a hospice election on all active and pending medicaid cases. If the 13-746 is not timely, count back 5 working days from the date of receipt to determine the authorization date.
5. The LTSS start date can be backdated for nursing facility services up to 3 months prior to the date of application on an applicant of medicaid as long as the client is nursing facility level of care (NFLOC) and financially eligible.
6. The LTSS start date for nursing facility services on an active medicaid recipient is based on the first date the admission is reported to DSHS as long as the client meets all other eligibility factors.

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WAC 182-503-0080 Washington apple health -- Application denials and withdrawals.

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Clarifying Information

What if the applicant withdraws their application and decides within 30 days they want to pursue the application?

If an applicant has withdrawn their request for medical benefits and decides they want to pursue the application, we will re-determine eligibility benefits without a new application as long as the client has notified the department within 30 days of the withdrawal. The financial worker would need to go over the original application to make sure there are no changes and proceed to determine eligibility.

Forms Used In the Application Process

The application process begins and the application date is established when the request for benefits is received. These are the forms used in the application process for long-term care services.

[HCA forms](#), including translations are found on the HCA forms website.

[DSHS forms](#), including translations are found on the DSHS forms website.

HCA [18-003](#) Rights and Responsibilities (Translations can be found at Health Care Authority (HCA) forms under [14-113](#))

HCA [18-005](#) Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled coverage

[HCA 18-008 Washington Apple Health Application for Tailored Supports for Older Adults \(TSOA\)](#)

[DSHS 14-001 Application for Cash or Food Assistance](#) This is used for any cash, food or medical care services (MCS) request as MCS is tied to ABD cash/HEN eligibility

HCA [14-194](#) Medical Coverage Information (Used to report third party insurance coverage including LTC insurance)

DSHS [14-539](#) Revocable Burial Fund Provision for SSI Related Healthcare

DSHS [14-540](#) Irrevocable Burial Fund Provision for SSI Related Healthcare

DSHS [14-454](#) Estate Recovery fact sheet. Repaying the State for Medical and Long Term Care (LTC)

DSHS [14-501](#) Community Resource Declaration (Used to evaluate resources (assets) for an applicant and their spouse based on date of institutionalization. WAC [182-513-1350](#))

DSHS [14-532](#) Authorized Representative Release of information.

DSHS [10-438](#) Long-Term Care Partnership (LTCP) Asset Designation form (Used to designate assets (resources) for those with a Long-term care partnership insurance policy)

DSHS [14-012](#) Consent (release of information form) (Used for all DSHS programs)

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Note: The [HCA 80-020 Authorization for Release of Information](#) is for medical benefits under Health Care Authority and will be accepted as a release of information for all Medical programs including [LTSS](#) programs. The DSHS consent form is preferred as it is used for all programs including medical, food and cash.

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Note: The term asset and resources means the same thing.

The Long-term Care Application Process - Who Makes the Eligibility Determinations

Financial staff determines financial eligibility by comparing the client's income, resources and circumstances to program criteria. Financial staff also determine participation amount in the cost of care.

Social service staff and case managers determine functional eligibility and what services to authorize based on a complete and comprehensive care assessment. The HCS social worker may contact the applicant to schedule a time to come to the client's home to do an assessment if the client is requesting personal care services.

Both functional and financial eligibility are done concurrently. Financial and social service staff must coordinate their activities in order to process applications and provide services to clients timely and efficiently. When a client is found both financially eligible and functionally eligible for [LTSS](#) and an approved provider is in place, then [LTSS](#) can begin.

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What is the Process for Nursing Facility Care?

For [Aged/Blind/Disabled](#) Washington Apple Health programs:

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1. Department-designated social service staff:
 1. Assess the client's functional eligibility for institutional care.
 2. Screen all clients to determine potential for home and community services.
 3. Determine if the client is likely to attain institutional status as described in WAC [182-513-1320](#). (Will the client be likely to reside at the nursing facility for 30 days or longer?) Notify the facility when the client doesn't appear to meet the need for NF care.
 4. Determine if a Housing Maintenance Allowance (HMA) (formerly Medical Institution Income Exemption (MIIE)) is appropriate. Instructions are found

in the LTC manual - Nursing Facility Case Management & relocation discharge resources.

5. Determine if there is potential for relocation and what level of intervention would be required following the procedures outlined in nursing facility case management.
6. Provide financial services staff with the following information:
 1. Date of NF admission
 2. Does the client meet nursing facility level of care (NFLOC)
 3. For Medicaid recipients, the first date DSHS was notified of the admission by the nursing facility
 4. If the client is likely to attain institutional status (projected in a medical facility for 30 days or more)
 5. The amount of housing maintenance exemption and the start date if appropriate.

2. Financial services staff:

1. Refer the client to the SW for a CA if the client contacts the FSS first and document the date the client first requested NF care.
2. Determine the client's financial eligibility for [LTSS](#) and non-institutional medical assistance including 3 months retroactive medical coverage if financially eligible.
3. Authorize payment for NF care if the client is both functionally and financially eligible.
 1. For Medicaid applicants, institutional services are approved based on the date the client is eligible up to 3 months prior to the date of application.
 2. For Medicaid recipients, institutional services are approved based on the first date the admission is known to DSHS as long as the client meets all other eligibility factors.
4. Issue the NF award letter to the applicant/recipient and the nursing facility.

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What is the Process of In-Home or Residential Waiver Services?

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This process applies to [aged/blind/disabled](#) programs only – MAGI-based clients are not eligible for HCBS waiver.

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1. Department-designated social service staff:
 1. Assess the client's functional eligibility for in home or residential care.
 2. Provide financial services staff with the following information:
 1. Service start date
 2. Type of service (CFC, COPEs, RCL, New Freedom, MPC, PACE)
 3. Residential facility name and address
2. Financial services staff:
 1. Refer the client to the SW for a CA if the client contacts the FSS first and document the date the client first requested in home or residential care.
 2. Give a projected participation and room and board amount to the SW using the LTC referral 07-104. Clearly indicate this is a projection and the financial application is in process.
 3. Determine the client's financial eligibility for [LTSS](#) medicaid and/or non-institutional medical assistance including a request for retro medical if needed.
 4. Authorize in ACES for in home or residential Waiver if the client is both functionally and financially eligible.
 5. Issue the award letter to the applicant/recipient.

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Note: Applications for residential services take priority. It is essential to start the process by referring to the [social worker](#) for an assessment as soon as an application for residential is received. Services can't be backdated prior to the date of the assessment.

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Clients switching from private pay to medicaid are advised to apply for benefits [30 to 45](#) days before being resource eligible for the program. There is good information on the [Washington LawHelp site](#) [that](#) explains the timing of an [LTSS](#) application.

What is the best practice guidelines for fast track?

[Fast Track is a social services process that allows the authorization of LTSS prior to a financial eligibility determination. Social services makes this determination by consulting financial staff who can reasonably conclude that the client will likely be financially eligible.](#)

Clients receiving services during the fast track period won't receive a medical services card until financial eligibility is established. Services may be authorized using fast track for a maximum of 90 days.

Fast track is the only way to start LTSS while Medicaid eligibility is in the process of being established.

Always attempt to contact client or representative to conduct an interview prior to considering Fast Track so that you have as much information as possible before making Fast Track decision. If you are unable to make contact, you should still make a Fast Track determination based on the information and verifications that you have available, and send this determination via 07-104 to social services after your first contact attempt.

Questions to consider if a client is likely eligible for Fast Track before an interview is completed:

- 1.) What resources is the client reporting on the application or past applications?
- 2.) Are transfers indicated?
- 3.) Did you receive verification of resources with the application?
- 4.) Have you received Accurint results and reviewed the assets reported?
- 5.) Is the client married or single? (Don't forget about spousal resource limits)

A Fast Track consideration can vary case-by-case based on the types of resources discovered during the interview and the client's current circumstances. For example, if an applicant reports a life insurance policy or burial fund that can be made irrevocable in order for the value to not be counted. Or, if an applicant is private paying in a residential facility, has been denied into 30 day reconsideration period for not providing verifications, yet claims to be running out of money to pay privately, then you may want to not consider Fast Track.

Social services can't begin fast track until a care assessment is completed. The determination of fast track is ultimately up to social services, not financial.

Don't open a case in ACES just because you have received a fast track agreement unless you have everything needed to establish financial eligibility.

If the client ends up not being financially eligible for services, notify social services. An overpayment is not established. Social services would need to state fund fast-track services when the person is found not financially eligible during the fast track period.