# Client Referral/Change Form
# CF-ES 2506A, 06/2014
# Instructions for Medicaid LTC Program

**Purpose:**
This form is used by Medicaid Nursing Facilities (NF) or Medicaid Long-Term Care (LTC) managed care plans to communicate with the Department of Children and Families (DCF) regarding individuals seeking nursing facility services or requesting a change to their Medicaid eligibility file. It should be used by the entities designated below for the following situations:

| Event | Responsible Party | Completing Form |
|---|---|---|
| ***Initial Eligibility***:<br>A resident needs Institutional Care Program (ICP) Medicaid | Nursing Facility | C**omplete Sections: Header, Top Left, Top Right, A, A.1., B**. |
| ***Initial LTC Plan enrollment:***<br>An LTC Program NF recipient has selected their first LTC plan, is now enrolled, and the LTC Plan needs to be listed as the case manager on record. | Medicaid LTC Plan or LTC plan case manager | **Complete Sections: Header, Top Left, Top Right, A, A.1, D.** |
| ***Change in LTC Plans:***<br>An LTC Program NF recipient changes LTC Plans and the new LTC Plan needs to be listed as the case manager on record. | *New* Medicaid LTC Plan or LTC plan case manager | **Complete Sections: Header, Top Left, Top Right, A, A.1, D.** |
| ***Community LTC Program enrollee moves to a NF:***<br>An individual residing in the community with Medicaid waiver eligibility (aid category code is MW A) and enrolled with a Medicaid LTC Plan is moving into a NF and will be receiving NF services. | Medicaid LTC Plan or LTC plan case manager | **Complete Sections: Header, Top Left, Top Right, A, A.1., B.** |
| ***Recipient Deceased:***<br>An individual enrolled with an LTC plan a NF member is now deceased. | Medicaid LTC Plan, LTC plan case manager, or NF | **Complete Sections: Header, Top Left, Top Right, A, A.1., C.** |
| ***Recipient Transfer/Move***<br>An individual residing in a NF and enrolled with an LTC plan is transferred/moves to another NF and the correct NF information must be updated. If the new location is a nursing facility, the 2515 form should NOT be used. Instead, the 2506A form should be completed and submitted to DCF. | Medicaid LTC Plan or LTC plan case manager | **Complete Sections: Header, Top Left, Top Right, A, A.1., C.** |
| ***Recipient Discharge***<br>An individual residing in a NF and enrolled with an LTC plan is discharged from the facility. If the discharge is to the community (ALF or private residence), and the individual will be receiving home and community based waiver services, the 2506A form should NOT be used. Instead, the 2515 form should be completed by the LTC Plan or LTC Plan case manager and submitted to DCF. | TBD – will ***not*** be the Medicaid LTC Plan or LTC plan case manager | **Complete Sections: Header, Top Left, Top Right, A, A.1., C.** |

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Section by Section Instructions

**Header Section:**

| | |
|---|---|
| *Case #* | For those residents who are already known to DCF's system, enter the resident's DCF assigned Case Number. Note: this is *not* the resident's 10-digit Medicaid ID number. |

**Top Left Section:**

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|---|---|
| *Local Fax #* | Enter the DCF local fax number used to fax the form. DCF local fax numbers can be located on the DCF website at the following link: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/locate-service-center-your-area |
| *Date* | Enter the date the form is being submitted/faxed to DCF. |

**Top Right Section:**

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|---|---|
| *From* | Enter the name of the entity that is submitting the form. This can either be the nursing facility in which the individual is residing or the Medicaid LTC managed care plan in which the resident is enrolled. |
| *Contact Name*<br>*Telephone #* | Enter the person's name, telephone number, and email address at either the nursing facility or the Medicaid LTC managed care plan who can answer any questions regarding the form's submission. |
| *Nursing Facility Address* | Enter the full address of the nursing facility where the individual is residing. |

**Section A: Resident's Information**

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|---|---|
| *Resident's name*<br>*SSN*<br>*Date of Birth*<br>*Medicaid ID#* | Enter the resident's demographic information including full name, social security number, date of birth, and Medicaid identification number (if known). |

**Section A1: Representative Information**

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|---|---|
| *Representative*<br>*Address*<br>*Telephone #*<br>*Relationship* | If the resident has an authorized representative, enter their name, full address, telephone number, and their relationship to the resident. This allows DCF to notify the representative regarding any activity on the resident's case. |

**Section B:**

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|---|---|
| This section should only be used if the resident does not have active Institutional Care Program (ICP) Medicaid eligibility verified on the Florida Medicaid Management Information System (FMMIS). ICP Medicaid eligibility categories are designated by codes beginning with 'MI*'. | |
| *Is the individual an SSI Direct Enrollee?* | Check the 'Yes' box if the resident currently has verified SSI Medicaid eligibility; this eligibility is designated by the code 'MS'. |

| | |
|---|---|
| *Active Aid Category/Coverage Group* | If the resident currently has verified Medicaid eligibility that is NOT 'MS', enter the aid category code. |
| *The resident was admitted to the above referenced facility on* | Enter the nursing facility admit date. |
| *From* | Check the appropriate box (Hospital, Home, ALF) where the resident was located prior to being admitted to the nursing facility. |
| *Prior Residential Address* | Enter the full address where the resident was residing prior to being admitted to the nursing facility. |

**Section C:**

| This section should be completed to report a resident's discharge or transfer when the resident is enrolled in a Medicaid LTC managed care plan. It should NOT be used if the resident is enrolled in a Medicaid LTC plan and will be receiving home and community-based waiver services upon discharge. In those instances, the LTC Plan must submit the 2515 form to DCF. | |
|---|---|
| *Resident Discharged/transferred from the facility on* | Enter the date the resident left the facility. |
| *To* | Check the appropriate box (ALF, Home, Hospital, Nursing Home, Other) where the resident was going upon discharge/transfer. If 'Other' is checked, please specify the location. Enter the full address for the ALF, Home, Hospital, or Other location. |
| *Due to Death on* | If the resident was discharged due to death, enter the date of death. |

**Section D:**

| This section should be completed by the resident's Medicaid LTC Plan to notify DCF when a nursing facility resident has enrolled in the Long-Term Care Managed Care Program. This section should also be used by the new Medicaid LTC Plan to notify DCF if the resident changes LTC Plans at a later date. This information allows the LTC plan/provider to be copied on DCF notices sent to the resident. | |
|---|---|
| *The above named resident has enrolled in a managed care plan. Effective date* | The LTC plan or its designee should check this box and enter the effective date when the resident is initially enrolled in the LTC Program with their plan. |
| *The above named recipient has <u>changed</u> managed care plans. Effective date* | The new LTC plan or its designee should check this box when the resident was previously enrolled with a Medicaid LTC plan and has now changed plans. Enter the effective date of enrollment with the new LTC plan. |
| *Managed Care Plan:* | Enter the name of the Medicaid LTC plan and contact information for the managed care plan in which the resident initially becomes enrolled or in which the resident becomes enrolled after a change, whichever is appropriate. Include the contact's name, full address, telephone number, and email address. |
| *MCP Contact Person Information* | |
| *Name* | |
| *Address* | |
| *Telephone #* | |
| *Email Address* | |