CERTIFICATION OF ENROLLMENT STATUS
HOME AND COMMUNITY BASED SERVICES (HCBS)
CF-ES 2515, 05/2017
Instructions for Medicaid LTC Program

Purpose:
This form is used to communicate with the Department of Children and Families (DCF) regarding home and community-based services (HCBS) waiver recipients. While the form is used by several Medicaid waiver providers, these instructions are specific to the Medicaid Managed Care Long-Term Care (LTC) Program waiver only. This form should be used by the entities designated below for the following situations:

Event	Responsible Party	Completing Form
Initial Eligibility: A waiver slot has been authorized for an individual and they have been determined medically eligible for the program; financial eligibility needs to be determined.	Aging and Disability Resource Centers (ADRCs)	**Check "Application" and complete Sections II., III. a) and b), IV., VI., and VII. e) (if appropriate)**
Initial LTC Plan enrollment: An LTC Program waiver 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	**Check "Change" and complete Sections II., IV., VI., and IX**.
Change in LTC Plans: An LTC Program waiver 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	**Check "Change" and complete Sections II., IV., VI., and IX**.
Nursing Facility Transition: An individual residing in a nursing facility with Institutional Care Program (ICP) eligibility (aid category codes beginning MI*) and enrolled with a Medicaid LTC Plan is transitioning into the community and will be receiving HCBS waiver services.	Medicaid LTC Plan or LTC plan case manager	**Check "Change" and complete sections II., III. d), IV.,VI., and VII.**
Recipient Deceased: An individual enrolled with an LTC plan as an HCBS member is now deceased.	Medicaid LTC Plan or LTC plan case manager	**Check "Change" and complete sections II., III. f), IV., and VI.**
Recipient Move An individual enrolled with an LTC plan as an HCBS member moves to another location. 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	**Check "Change" and complete sections II., III. d), IV., VI, and VII.**
Disenrollment An individual enrolled with an LTC plans requests a disenrollment from the program.	TBD – will ***not*** be the Medicaid LTC Plan or LTC plan case manager	

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Section by Section Instructions

Header Section:

Application	Check this box when the information contained on the form is for an individual applying for Medicaid HCBS waiver eligibility; if the individual already has existing Medicaid (other than SSI coverage, i.e., MS aid category code), select the "change" box.
Change	Check this box when the information contained on the form is for an individual already receiving HCBS eligibility or already receiving another form of Medicaid eligibility (other than SSI) and needs to change to HCBS eligibility.

Section II.

Name of Applicant/Recipient	Enter the full name of the individual for whom the request is being made, their social security number, and, if appropriate, their designated/authorized representative.
Client Social Security Number	
Designated Representative	

Section III.

Check the appropriate box for either a), b), c), d), e) or f)	
a) was enrolled in the Medicaid (HCBS) waiver on…	Enter the date the applicant was initially authorized to be enrolled in the LTC Program waiver. **This information should be completed by the ADRC only.**
b) Level of Care effective date:	Check the appropriate Level of Care box (Skilled, Intermediate I, Intermediate II) and enter the Level of Care effective date. **This information should be completed by the ADRC only.**
c) will not be enrolled in the Medicaid HCBS waiver	If the individual filed an application with DCF to receive HCBS but will not be enrolled in the waiver, enter the reason why. For the LTC Program, this item should only be completed by the ADRC or CARES staff.
d) has a change in living arrangement	If there has been any change in the individual's living arrangement, this box must be checked and the accompanying information in Section VII., must also be completed in its entirety.
e) was disenrolled from the Medicaid waiver (HCBS) on:	This section should never be completed by the LTC Plan/case manager.
f) died on	Enter the date of death for the individual.

Section IV.

Case Management Agency	For the LTC Program, enter either the ADRC's agency name or the LTC Plan's name. This information will be included in the individual's record in order to receive future eligibility notices.
Waiver Program	Enter **SMMC LTC Program**
Mailing Address	Enter either the corresponding ADRC full address or LTC Plan's full address in order to receive copies of the eligibility notices.
Telephone Number (include area code)	Enter either the ADRC's phone number or the LTC Plan's phone number.

Section VI.

Certified By: *Case Manager's Name (print)*	The individual completing the form at the ADRC or the LTC Plan must print their name, sign, and date the form prior to submitting the document to DCF. This individual should be knowledgeable to answer any questions regarding the submitted form.
Case Manager's Signature	
Date	

Section VII. LIVING ARRANGEMENT INFORMATION:

a) Previous address:	Enter the full address for where the individual was living prior to the change being reported. This applies to Nursing Facility transitions as well as community moves.
b) New address:	Enter the full address for where the individual is now residing.
c) Effective date of new address:	Enter the actual date when the individual moved.
d) Note type of living arrangement	Indicate whether or not the individual is now living in the community, has moved into an Assisted Living Facility (ALF), etc. If the individual has moved into a nursing facility and will need ICP Medicaid, STOP. Do not use this form. Submit the 2506A form to DCF.
e) For ALFs only: Usual and Customary Room and Board Rate documentation provided:	Enter the customary room and board rate. This rate is needed in order to appropriately calculate the individual's patient responsibility amount and complete the financial eligibility.

Section VIII. CASE MANAGER COORDINATION CHECKLIST:

Has a current DCF eligibility specialist been notified?	This section should only be used to alert DCF that the 2515 is a resubmission from a prior request. If known that the current submission of the form is a resubmission for the same event, check yes. If not, check no.
No/Yes	
Date	

Section IX. NEW CASE MANAGER INFORMATION:

Recipient transferred to another Medicaid waiver Case Manager on (date):	For the LTC Program, when an individual first becomes enrolled with a Medicaid managed care LTC Plan and if/when the individual changes LTC plans, the new LTC Plan should complete this section. Enter the new LTC Plan's name, the name of the assigned contact who can answer any questions regarding the individual's enrollment into the plan/waiver, the LTC Plan's full mailing address, and telephone number where the contact person can be reached.
Case Management Agency:	
Contact Person:	
Mailing Address:	
Telephone Number:	