



Instructions for Completing Lead Agency Assessor/Case Manager/Worker LTC Communication Form (DHS-5181)

Use of the Lead Agency Assessor/Case Manager/Worker Communication Form (DHS-5181) is mandatory. The form is a tool for communication between lead agency assessors/case managers and workers who determine eligibility for MA payment of long-term care (LTC) services.

Part 1 is completed by lead agency assessors and case managers and Part 2 is completed by county or tribal financial workers.

Lead Agency Assessor Responsibilities

Lead agency assessors share information regarding the results of a LTCC assessment for:

- MA applicants or enrollees who request services through a HCBS waiver.
- MA applicants or enrollees who request payment of LTC services in an LTCF.

Complete Part 1 Sections A, B and D.

- Section A - Contact Information.
 - Provide your contact information and identify the client.
- Section B - Status.
 - Provide the assessment date and the anticipated start date of waiver services whenever applicable.
 - Provide information about the client's level of care (LOC) for either a HCBS waiver program or a stay in a LTCF. Indicate whether:
 - the client has applied for MA or,
 - if an application form was given to the client or,
 - if the worker needs to send the application form and/or the asset assessment form to the client.

Changes completed by the Assessor

- Section D. Comments.
 - Provide or request additional information.

When Part 1 is completed send the DHS-5181 via fax, interoffice mail or U.S. mail to the county or tribal agency worker immediately.

Assist the client with completing the Request for Payment of Long-Term Care Services (DHS-3543) when requested by the client or the client's authorized representative, or when the worker sends a DHS-5181, Part 2 indicating that the client has not returned a required DHS-3543.

Lead Agency Case Manager Responsibilities

Lead agency case managers need to communicate to workers changes for MA enrollees who are receiving services through a HCBS waiver or in a LTCF and experience a change in circumstances; for example, move to an LTCF or between LTCFs, exit the HCBS waiver, or move to a different HCBS waiver program.

Complete Part 1 Sections A, C and D of the DHS-5181.

- Section A - Contact Information.
 - Provide your contact information and identify the client.
- Section C - Changes.

Indicate when the client

 - exited the waiver
 - changed waiver programs

- moved to a LTCF
- changed to a new LTCF
- died
- was disenrolled from a managed care plan due to moving
- Section D. Comments.
 - Provide or request additional information.

When Part I is completed send the DHS-5181 via fax, interoffice mail or U.S. mail to the county or tribal agency worker immediately.

Worker Responsibilities

Part 2 of the DHS-5181 includes the following sections:

- Section E - Contact Information.
 - Provide your contact information and identify the client.
- Section F - Medical Assistance (MA) Status for LTC services.
 - Provide information about the requested forms being sent to the client, the client's MA eligibility status and the results of an asset assessment if appropriate.
- Section G - Comments.
 - Provide or request additional information.

Complete all sections of Part 2 and send the DHS-5181 via fax, interoffice mail or U.S. mail to the lead agency assessor/case manager.

- within 10 working days after receiving the DHS-5181 with Part 1 completed if eligibility for MA payment of LTC services has not yet been determined. Indicate on the form if the determination is still pending or if the MA enrollee has not returned the DHS-3543. Keep a copy of the completed form in the case file.

Note: The Lead Agency Assessor must follow up with the client when the reason the MA eligibility determination has not been made is because the MA enrollee has not returned the DHS-3543.

- 45 days after first receiving the completed Part 1 if eligibility can still not be determined.
- immediately upon approval or denial of a client's request for MA payment of LTC services.
- immediately after processing a change, including:
 - Address change.
 - Termination of eligibility for MA or MA payment of LTC services.
 - Death.
 - Move to a LTCCF.
 - Other.

Make a referral to the lead agency LTCC team when:

- An applicant or enrollee files a request for MA payment of LTC services by completing a Minnesota Health Care Programs Application for Payment of Long-Term Care Services (DHS-3531) or DHS-3543.
- an assessor has not provided a Lead Agency Assessor/Case Manager/Worker Communication Form (DHS-5181) that indicates the client meets the institutional level of need requirement.

SECTION B – Status

Medical Assistance Requests/Applications

Client applied for MA

Client is an MA enrollee – Assessor provided DHS-3543 on _____
DATE

Completed DHS-3543 or DHS-3531 attached

Completed DHS-3543 or DHS-3531 faxed to county on: _____
DATE

Please send DHS-3543 to client (MA enrollee)

Please send DHS-3531 to client (Not MA enrollee) _____
ADDRESS

Please send DHS-3340 to client – Asset Assessment needed

Changes completed by the Assessor

Client no longer meets LOC – Effective date should be no sooner than: _____
DATE

(Date must be at least 30 days after assessor sends notification to the person that he/she no longer meets the LOC)

Waiver program change from _____ to _____ effective _____
DATE

SECTION C – Changes

CHANGES (check all that apply)

Exited waiver program _____
EFFECTIVE DATE

Client's choice

Client deceased _____
DATE OF DEATH

Client moved to long-term care facility on _____
DATE FACILITY NAME

Waiver program change from _____ to _____ effective _____

Client disenrolled from health plan _____
EFFECTIVE DATE

New address _____
ADDRESS DATE ADDRESS CHANGED

Other: _____

SECTION D – Comments

Part 2: To be completed by the worker	DATE
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SECTION E – Contact Information

TO			FROM		
_____, Lead Agency Assessor/Case Manager			_____, Worker		
LEAD AGENCY			COUNTY/TRIBAL AGENCY		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
FAX NUMBER	PHONE NUMBER		FAX NUMBER	PHONE NUMBER	
CLIENT NAME			DATE OF BIRTH	PMI NUMBER	CASE NUMBER

SECTION F – Medical Assistance (MA) Status for LTC Services

Applied for MA-LTC _____
DATE APPLIED

DHS-3531 sent to client on: _____
DATE

DHS-3543 sent to client on: _____
DATE

DHS-3543/DHS-3531 has been returned; eligibility determination pending

DHS-3543/DHS-3531 has not been returned

Determination

MA opened _____
EFFECTIVE DATE

Basic MA Medical Spenddown \$ _____

MA for LTC services open effective _____
DATE

LTC spenddown/waiver obligation for initial month: _____

MA denied _____
EFFECTIVE DATE

MA payment of LTC services denied _____
EFFECTIVE DATE

Client is ineligible for MA payment of LTC services until: _____
DATE

Basic MA continues until: _____
DATE

Results from the Asset Assessment have been sent to client

SECTION F – Medical Assistance (MA) Status for LTC Services

CHANGES

MA terminated _____ (Basic MA and MA payment of LTC services)
EFFECTIVE DATE

MA spenddown \$ _____

MA payment of LTC services terminated _____, Basic MA remains open.
EFFECTIVE DATE

Client is ineligible for MA payment of LTC services until: _____
DATE

Client deceased _____
DATE OF DEATH

Client moved to long-term care facility on _____ FACILITY NAME
DATE

New address _____ ADDRESS DATE ADDRESS CHANGED

Other: _____

SECTION G – Comments

Large empty rectangular box for entering comments.