Community Long Term Care Needs Assessment

Member Name: **Date of Assessment:** **MID #:**

The following information was obtained on the date of assessment.

CCM Phone Number: 800-863-6068 Fax: 508-421-5905
E-mail: CommCase@umassmed.edu

Clinical Manager:

Demographic Information

DOB:

Member's Address:

Phone Number: **Alternate Phone Number**:

Name of Parent [ ] or Guardian [ ]:

Member lives in Group Home:
If Yes, Name and Phone number of Group Home contact:
Primary contact for member: Guardian: **Group Home**:

Is Member in foster care?:
If Yes, name and phone number of DCF Contact:

Is Member followed by DPPC/DDS:
If Yes, name and phone number of DPPC/DDS contact:

Primary Language Spoken: **Interpreter needed? Yes [ ] No [ ]**
Name of interpreter:

Medical Information

Height: inches [ ] cm [ ]	**Weight**: lbs. [ ] kg [ ]	**Allergies**:
Gestational Age:	**Immunizations up to date?**	**If no, reason**:

Diagnoses

Primary Diagnosis:

Associated Diagnoses:

Physician & Hospital Information

Name	Location	Specialty	Office Number

Medications

Medication	Dose	Route	Frequency

Medical History

List who was present during the visit including the Member:

Primary Caregiver: **Relationship**:

Location of Assessment:

Hospital Contact if Appropriate:

Proposed Discharge Date if Appropriate:

Hospitalizations in the Past Year

N/A (Not Applicable) [ ] **UTA (Unable to Assess) [ ]**

Month of Hospitalization	Reason	Number of Days

Emergency Room Visits in the Past year

N/A [ ] **UTA [ ]**

Month of E.R. Visit	Reason

Current Home Care Services

NA [ ] UTA [ ]

Service	Authorized (# of hours/wk)	Filled (# of hours/wk)

Community Long Term Care Needs Assessment

Member Name: **Date of Assessment:** **MID #:**

CSN		
CSN/PCA option		
SNV		
HHA		
PCA		

If not filled, explain:

Are there other members in the home receiving CSN?:

If yes: List the name of member(s), the number of hours per week authorized and the provider(s) involved:

Does the primary caregiver(s) and, if applicable, the member feel they have received a proper in-service and training from the servicing provider(s) for the skilled nursing services and the equipment?: [ ] Yes or [ ] No

If "no", have you requested further training?: [ ] Yes or [ ] No

CLTC Service(s) paid for by private insurance, including Medicare:

Independent Motor Status/Self Care

[ ] Unable [ ] Holds Head Up [ ] Roll [ ] Sit [ ] Crawl [ ] Walk

ADLs	Age app	Independent	Needs assist	1 assist	2 assists
Transfers					
Bathing					
Toileting					
Dressing					

How does your child communicate to you:

Current Equipment in Use

Suction machine	[ ]	**Bed (Type, Mattresses, and Specialty Beds)**	[ ]
Pulse oximeter	[ ]	**Strollers, Wheelchairs**	[ ]
Mechanical ventilation []CPAP []BIPAP []Vent	[ ]	**Seating (Activity Chairs, High/Low Chairs, Other)**	[ ]
Oxygen [ ]gas [ ]liquid [ ]stationary [ ]portable		**Transfer (Type of Lift)**	[ ]
O2 Concentrator	[ ]	**Cervical support devices**	[ ]
Compressor (mist)	[ ]	**Body Jacket**	[ ]

Member Name: **Date of Assessment:** **MID #:**

Percussor	[ ]	**Hand splints**	[ ]
Inexsufflator	[ ]	**AFO's**	[ ]
HFCWO vest	[ ]	**Helmets**	[ ]
Nebulizer	[ ]	**Car Seat**	[ ]
AMBU	[ ]	**Stander/type**	[ ]
Tracheostomy tubes/backups **Type:** **Size:**	[ ]	**Gait Trainer**	[ ]
HME/Thermovent	[ ]	**Shower /bath chair/describe**	[ ]
Passey Muir Speaking Valve and/or tracheostomy cap	[ ] [ ]	**Communication Equipment (Devices/Software)**	[ ]
BP cuff/dynamap	[ ]	**Commodes**	[ ]
Feeding pump	[ ]	**Walker**	[ ]
NG/NJ/ND/G/J tubes	[ ]	**Adaptive Aids (list)**	[ ]
IV/CVL/PICC/Broviac/POC	[ ]		
Urinary catheters	[ ]	**Other equipment:**	[ ]

Member Name: **Date of Assessment:** **MID #:**

Ostomy bags	[ ]		
Wound vac	[ ]		

COMMUNITY SERVICES

List all currently involved agencies and the services they are providing:

State Agencies

If applicable, list services (including respite, case management and residential services) that are provided by other sources such as the Massachusetts Commission for the Blind, the Department of Public Health, the Department of Children and Families, the Department of Education, The Department of Mental Health, The Department of Developmental Services, and an early intervention program. Include the frequency of service and the name and telephone number of the case manager.

NA [ ] UTA [ ]

List here:

Signed plan obtained from family? (IFSP, IEP, 504, ISP): [ ] Yes or [ ] No

AFC/GAFC Plan of Care received from agency providing AFC?: [ ] Yes or [ ] No

Services provided:

If "no" please explain:

EI [ ] School [ ] Dayhab [ ]

School/Program Name:

Service	Frequency	Payer (school/insurance):
CSN		
PT		
OT		
Speech		
Other		

Therapies Outside of Educational Plan

Service	Frequency/location (home, outpatient, etc)	Payer
PT		
OT		
Speech		
Other		

Other (support groups, community affiliations):

Review CCM services available (see CCM Specialist insert): [ ]

Would you like to speak with any of the Specialists (if yes, about what)?:

Comments:

Review of Nursing/Medical Reports

Nursing Progress Notes	**[ ] Yes or**	**[ ] No**	
485/Plan of Care	**[ ] Yes or**	**[ ] No**	
Hospital Discharge Summary	**[ ] Yes or**	**[ ] No**	**[ ] N/A**
Other Supportive Medical Records	**[ ] Yes or**	**[ ] No**	**[ ] N/A**
MassHealth Claims reviewed	**[ ] Yes or**	**[ ] No**	**[ ] N/A**
MassHealth Eligibility Reviewed	**[ ] Yes or**	**[ ] No**	**[ ] N/A**

[ ] N/A [ ] UTA

Please list below all who participated in this assessment, including their credentials and/or relationship to Member:

Follow-up Items:

Member Name: **Date of Assessment:** **MID #:**

Community Case Management
Individualized Assessment for Skilled Nursing Needs

Revised 2/7/2012

Member Name:	Date of Assessment:		MID:	DOB:
Nursing Interventions	**Time (in minutes)**	**Frequency (x per day)**	**Clinical Rationale/Medical Necessity**	**Total minutes per day**
Teaching needs of the caregiver				
Respiratory				
Tracheostomy care	0.00	0.00		0.00
Suction Type/frequency	0.00	0.00		0.00
Mechanical Ventilation Care Management (CPAP, BIPAP, Ventilator)	0.00	0.00		0.00
O2 Desaturations frequency	0.00	0.00		0.00
Oxygen	0.00	0.00		0.00
Chest physiotherapy /frequency	0.00	0.00		0.00
Nebulizer treatments	0.00	0.00		0.00
Inhalers	0.00	0.00		0.00
Skilled Assessment/respiratory	0.00	0.00		0.00
Cardiac/Autonomic Instability				
Skilled assessment/cardiac	0.00	0.00		0.00
Gastro-Intestinal (GI)/Nutrition				
Oral feeds/frequency-*only scored if at risk for aspiration	0.00	0.00		0.00
NG/ NJ/ND tube feeds/frequency	0.00	0.00		0.00
G/J tube Care frequency	0.00	0.00		0.00
G/J tube feedings frequency	0.00	0.00		0.00
Adjustments and Venting frequency	0.00	0.00		0.00
Intake and Output frequency	0.00	0.00		0.00
Elimination management/frequency	0.00	0.00		0.00
CVL/PICC/Broviac Care	0.00	0.00		0.00
Parenteral line assessment	0.00	0.00		0.00

Community Case Management

Individualized Assessment for Skilled Nursing Needs

Revised 2/7/2012

Member Name:	Date of Assessment:		MID:	DOB:
Nursing Interventions	**Time (in minutes)**	**Frequency (x per day)**	**Clinical Rationale/Medical Necessity**	**Total minutes per day**
TPN infusion management/frequency	0.00	0.00		0.00
Skilled Assessment/GI	0.00	0.00		0.00
Genito-Urinary (GU)				
Catheter care/frequency	0.00	0.00		0.00
Ostomies care/frequency	0.00	0.00		0.00
Skilled assessment/GU	0.00	0.00		0.00
Wound Care/Skin				
Wound Care frequency	0.00	0.00		0.00
Skilled assessment/Skin	0.00	0.00		0.00
Neurological				
Seizures frequency	0.00	0.00		0.00
Skilled assessment/neurological	0.00	0.00		0.00
Pain Management				
Pain management frequency:	0.00	0.00		0.00
Skilled assessment/Pain	0.00	0.00		0.00
Musculoskeletal				
Skilled assessment/Musculoskeletal	0.00	0.00		0.00
Other considerations in Skilled Care Needs				
Skilled assessment needs related to fluctuation in Medical status:	0.00	0.00		0.00
Is there any other information about your child's care that you would like to add to this assessment?				

Community Case Management

Individualized Assessment for Skilled Nursing Needs

Revised 2/7/2012

Member Name:	Date of Assessment:	MID:	DOB:

Nursing Interventions	Time (in minutes)	Frequency (x per day)	Clinical Rationale/Medical Necessity	Total minutes per day
In-School nursing paid by school/# hours 130 CMR 517.008				
CSN paid by another source/# hours 130 CMR 517.008				
* Insurance				
* State agency				
Assessment completed by:	Total minutes			**0.00**
Abimelech Velazco,	Total hrs/wk			**0.00**

COMMUNITY CASE MANAGEMENT (CCM) - SERVICE RECORD

Date of Assessment: **[ ] Initial Assessment [ ] Re-assessment** [ ] N/A

Date Service Record Mailed for Member's Signature:

DEMOGRAPHIC INFORMATION

Member Name:	MassHealth MID:
Primary Residence:	Birth Date: Age: Gender:
Phone Number:	Name of Clinical Manager:
Alternate Phone Number:	Signature of Clinical Manager:
Name of Primary Caregiver:	Assessment Location: Other:

MEDICAL INFORMATION

Primary Diagnosis:

Associated Diagnoses:

APPROVED MASSHEALTH LONG TERM SERVICES AND SUPPORTS (LTSS)

The services listed below have been approved in accordance with MassHealth Regulations, including but not limited to: 130 CMR 450.204, 130 CMR 403.000, 130 CMR 414.000, 130 CMR 503.000, 130 CMR 422.000

Nursing/PCA Provider	Service Type	Payer	Frequency	Duration	Start Date	End Date

CSN Authorized Hours: [] Unchanged [] Increased [] Decreased

If CSN Authorized Hours Increased or Decreased, list areas impacting decision:

PCA Authorized Hours: [] Unchanged [] Increased [] Decreased

If PCA Authorized Hours Increased or Decreased, list areas impacting decision:

All other MassHealth prior authorization requests for Long Term Services and Supports will be reviewed by CCM in accordance with MassHealth Regulations, including but not limited to: 130 CMR 450.204, 130 CMR 403.000, 130 CMR 427.000, 130 CMR 503.000, 130 CMR 409.000, 130 CMR 442.000, 130 CMR 428.000.

Oxygen/Respiratory Supplies Durable Medical Equipment and Medical Supplies Orthotics/Prosthetics Home Health Therapy Services

Member Name: Date of Assessment:

THIRD PARTY LIABILITY INFORMATION

[ ] N/A

Insurance Carrier:	Case Manager Name (if available):
Policy Holder Name:	Phone Number:
Policy Number(s):	Is other Parent/Legal Guardian Employed? If yes, Employee Name:
Group #:	Employer Name:

New TPL? [ ] Yes [ ] No

COMMUNITY CASE MANAGEMENT (CCM) SERVICE RECORD

The CCM Clinical Manager is responsible for assessing and authorizing all of your MassHealth Long Term Services and Supports (LTSS). If you have been authorized for continuous skilled nursing services, then the Clinical Manager will be the single point of entry for all your MassHealth LTSS service requests. LTSS services include nursing, personal care attendant, home health aide, durable medical equipment and supplies, oxygen and respiratory, and therapies.

The Clinical Manager will provide you with a list of MassHealth continuous skilled nursing providers and, if appropriate, personal care management providers.

The member is responsible for choosing and contacting a MassHealth provider for services that have been authorized. The member should contact the Clinical Manager at 508.856.8292 whenever the member's health condition changes, including hospitalizations, when insurance coverage has changed, or if you need assistance accessing MassHealth LTSS authorized services.

OTHER INFORMATION PROVIDED

SERVICE CONTRACT

☐ Agree ☐ Disagree with the above Service Record

Signature: _____ Print Name: _____ Date: _____

Relationship to Member: _____

If you disagree with the Service Record, per the instructions and timeframes detailed on the *Complaint, Dispute & Appeals Process* document provided to you, you may:

1. Request an informal review with CCM
2. Request a Fair Hearing with the Board of Hearings
3. Request both an informal review and a Fair Hearing with the Board of Hearings

RIGHT TO APPEAL

I have been informed of the appeal process. I have received a copy of the Fair Hearing Request Form and understand that I have the right to file an appeal and receive a fair hearing before an impartial hearing officer from the Board of Hearings.

Signature: _____ Print Name: _____ Date: _____

Relationship to Member: _____

☒ Member Copy

☐ CCM Copy

CCM Hours of Operation: Monday - Friday 8:30 AM - 5:00 PM
1-800-863-6068

HOW TO ASK FOR A FAIR HEARING

Your Right to Appeal: If you disagree with the action taken by MassHealth, you have the right to appeal and ask for a hearing before an impartial hearing officer. You can also request a hearing if MassHealth did not act on your request in a reasonable time.

How to Appeal: You can fill out this hearing request form and send it with a copy of the notice you are appealing to the **Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th floor, Quincy, MA 02171** or you can fax or efax these materials to **(617) 887-8797**. You can also call **(800) 841-2900** to fill out your request for a hearing form by telephone. If you have a question about your hearing, call (**617) 847-1200** or **(800) 655-0338**.

The Board of Hearings must receive your completed, signed request within 30 calendar days from the date you received the notice of our action. If you did not receive a written notice of the action to be taken, or MassHealth did not take an action on your application, you must file your request no later than 120 calendar days from the date the action took place or the date of the application.

If You Are Now Getting MassHealth Benefits: You may be eligible to keep your benefits between the time you appeal and the time that the Board of Hearings makes a decision to approve or deny your appeal. If you decide to keep your benefits between the time the appeal is pending, and then you lose your appeal, you may have to pay back the cost of the benefits you received. If you do not get benefits, and then you win your appeal, we will restore your benefits. You will keep your benefits if the hearing formis received either before the benefit stops or within 10 calendar days from the mailing date of the MassHealth notice, whichever is later. Please mark your choice in the **Other Information** section of the form.

Date of Fair Hearing: At least 10 days before the hearing, we will send you a notice telling you the date, time, and place of the hearing. Your hearing may be conducted by phone. You can ask us to reschedule a hearing, but you must have good cause. If you do not reschedule or appear on time to the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may have a lawyer or other person represent you, or you may represent yourself. We will not pay for anyone to represent you. You may contact a local legal aid service or community agency to see if you can receive advice or representation at no cost. A hearing request can also be filed on your behalf by an individual authorized to act on your behalf. If someone other than a lawyer is acting on your behalf, please attach a copy of the document(s) authorizing that person to file a hearing request on your behalf (for example, Power of Attorney, Guardian, invoked Health Care Proxy).

If You Need an Interpreter, Assistive Device, or Other Accommodation: If you do not understand English or if you are hearing or sight impaired, we will provide an interpreter or assistive device at the hearing at no cost to you. We will also make other reasonable accommodations a person with a disability may need to participate in the hearing. Please tell us what you need in the **Other Information** section of the form.

Your Right to Review Your Case File: You and/or your representative can review your case file before the hearing. If you wish to review your case file, call (800) 841-2900, TTY: (800) 497-4648 (for people who are deaf, hard of hearing, or speech disabled).

Your Right to Ask to Subpoena Witnesses and Your Right to Question: You or yourrepresentative may write to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnessesat the hearing. This means you can ask questions of witnesses. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members: Note that an appeal decision for one household member may change eligibility for other household members. If that happens, affected household members will receive a new eligibility notice explaining the changes.

FAIR HEARING REQUEST FORM

First Name: Middle Initial:

Last Name:

Mailing Address:

City: State: Zip:

Phone Number:

Member ID: Date of Birth:

Reason For Your Appeal (Circle any reason(s) that may apply.)
Income • Citizenship/Immigration status • Access to other insurance
Family size • Residency • Incarceration status • Other (see below)

Please explain why you are appealing.
Attach any documents that support your reason.

Other Information (Check all that apply.)

☐ I accept the proposed change in my coverage during the appeal process. If you check this line and you win your appeal, we will restore your original level of benefits.

☐ I want to keep the benefits during the appeal process that I was receiving before. If you check this line and you lose your appeal, you may have to pay back the cost of the benefits you received during your appeal.

☐ I need an interpreter. My language is _____
(We will provide the interpreter for the hearing.)

☐ I need an assistive device to communicate at a hearing. (Describe what type of device you need, and we will provide an assistive device for the hearing.)

☐ I need another accommodation for a disability.
(Describe the accommodation needed.)

☐ I need an expedited hearing.

☐ I want a phone hearing. My number is _____

Appeal Representative, if you have one

Name:

Phone number:

Mailing Address:

City: State: Zip:

Signature

The information on this form is true and accurate, to the best of my knowledge. I authorize MassHealth to provide me and my representative, if I have one, with my individual information, including federal and state tax information used inthe determination of my eligibility, for purposes of this appeal process.

Signature: Date:

First & Last Name (Print):

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, please attach a copy of your authority to file the appeal on behalf of the appellant (for example, a copy of your power of attorney document or evidence of court appointment as a personal representative).

Community Case Management
Commonwealth Medicine
University of Massachusetts Medical School
333 South Street
Shrewsbury, MA 01545
Office: 800-863-6068 TTY: 508-421-6129
Fax: 508-421-5905 E-mail: CommCase@umassmed.edu

Community Case Management (CCM)
Complaint, Dispute & Appeals Process

Filing a Complaint

If at any time during your participation in Community Case Management (CCM) you are not happy with the way you were treated or the assistance you received from a CCM staff member, you may file a complaint with the appropriate manager via telephone (please refer to the contact information below) or in writing. Written complaints should be sent to Kerri Ikenberry at the address above. CCM will respond to your complaint within one (1) business day and resolve your issue within seven (7) business days.

Requesting a Fair Hearing with the Board of Hearings

If you disagree with the services authorized on your CCM Service Record during your Community Long Term Care Needs Assessment visit or any CCM prior authorization decision, you can file a request for fair hearing with the Board of Hearings by completing the ***Fair Hearing Request Form*** provided to you, and forwarding it to the address on the form. You must file a request for fair hearing with the Board of Hearings within thirty (30) calendar days of the Service Record date or prior authorization decision notice date (received via mail from MassHealth), if a Service Record wasn't provided. If you need an additional copy of the ***Fair Hearing Request Form*** please contact your Clinical Manager, or you may download the form from the MassHealth website at https://www.mass.gov/how-to/how-to-appeal-a-masshealth-decision.

In addition, following your request for a fair hearing, the Associate Director of Appeals & Regulatory Compliance will contact you prior to your scheduled fair hearing to ask if you would like to participate in an informal review.

Community Case Management: Contact Information		
Virdany Ruiz, BS, RRT	Clinical Coordinator, Allied Health Services: Manager - CCM Specialists: Occupational, Physical and Respiratory Therapy	(774) 455-5185
Terri Podgorni, RN, BSN	Associate Director, Care Management: Manager – CCM Clinical Managers (Nurses)	(508) 856-3982
Linda Phillips, RN	Associate Director, Appeals & Regulatory Compliance	(508) 856-1641
Kerri Ikenberry, RN	Executive Director, Community Based Services	(508) 421-5901