



Health Coverage Fax Cover Sheet for Family Assistance Long Term Services and Supports (LTSS) Pathway

Important Message

- Please use a separate cover sheet for each individual.
- DO NOT use the same cover sheet to send items for more than one individual.
- Please fax all materials including **both sides** of double-sided documents.
- Fax all materials with this cover sheet to **(774) 455-8155**.

TO	
Organization:	Disability Evaluation Services (DES)
Program	Nursing Facility Level of Care
Fax Number:	(774) 455-8155
Phone Number:	(800) 888-3420

FROM	
Organization:	
Sender Name:	
Fax Number:	
Phone Number:	

Number of Pages (including cover sheet):

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Applicant/Member Information

<input type="text"/>		<input type="text"/>	
Last Name		First Name	
<input type="text"/>	<input type="text"/>		<input type="text"/>
Last 4 digits of Social Security Number	MassHealth ID Number <i>(if applicable)</i>	Date of Birth <i>(MM/DD/YYYY)</i>	
<input type="text"/>		<input type="text"/>	
Preferred Spoken Language		Preferred Written Language	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Residential Street Address	City	State	Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Street Address	City	State	Zip code
<input type="text"/>	<input type="text"/>		
Cell Phone Number	Home Phone Number		

Evaluator Information

<input type="text"/>		<input type="text"/>	
Last Name		First Name	
<input type="text"/>		<input type="text"/>	
Credentials		Phone Number	
Evaluator Organization Type	<input type="checkbox"/> Disability and Community-based Services (DCS)		
	<input type="checkbox"/> Hospital	Name:	<input type="text"/>
	<input type="checkbox"/> Nursing Facility	Name:	<input type="text"/>
	<input type="checkbox"/> CDRH	Name:	<input type="text"/>
	<input type="checkbox"/> Other	Name:	<input type="text"/>



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Type of Referral
Initial Review
<input type="checkbox"/> Individual is discharging from a hospital and is newly applying for the Family Assistance LTSS Pathway. From the hospital, the individual is looking to discharge directly to: <input type="checkbox"/> Long-term services and supports in the community <input type="checkbox"/> A nursing facility or CDRH stay that is expected to be longer than six months
<input type="checkbox"/> Individual is discharging from a short-term (under 6 month) stay at a skilled nursing facility (SNF) or chronic disease and rehabilitation hospital (CDRH) and is newly applying for the Family Assistance LTSS Pathway. The individual is looking to transition to: <input type="checkbox"/> Long-term services and supports in the community <input type="checkbox"/> A nursing facility or CDRH stay that is expected to be longer than six months
Re-evaluation
<input type="checkbox"/> Individual is already in the Family Assistance LTSS Pathway and is due for a re-evaluation.

Instructions

For further information about the Family Assistance LTSS Pathway, including a list of required clinical documentation to be submitted with this fax cover sheet, please refer to the following MassHealth provider bulletins:

- [Acute Inpatient Hospital Bulletin 204](#)
- [Psychiatric Inpatient Hospital Bulletin 28](#)
- [Nursing Facilities Bulletin 193](#)
- [Chronic Disease and Rehabilitation Inpatient Hospital Bulletin 104](#)