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):

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

Applicant/Member Information

Last Name

First Name

Last 4 digits of Social Security Number

MassHealth ID Number *(if applicable)*

Date of Birth *(MM/DD/YYYY)*

Preferred Spoken Language

Preferred Written Language

Residential Street Address

City

State

Zip code

Mailing Street Address

City

State

Zip code

Cell Phone Number

Home Phone Number

Evaluator Information

Last Name

First Name

Credentials

Phone Number

Evaluator Organization Type

- ☐ **Disability and Community-based Services (DCS)**
- ☐ **Hospital** **Name:**
- ☐ **Nursing Facility** **Name:**
- ☐ **CDRH** **Name:**
- ☐ **Other** **Name:**

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Type of Referral
Initial Review
☐ 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: ☐ Long-term services and supports in the community ☐ A nursing facility or CDRH stay that is expected to be longer than six months
☐ 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: ☐ Long-term services and supports in the community ☐ A nursing facility or CDRH stay that is expected to be longer than six months
Re-evaluation
☐ 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*