



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth



**MassHealth
Home Health Agency Bulletin 45
November 2006**

TO: Home Health Agencies Participating in MassHealth
FROM: Beth Waldman, Medicaid Director *BW*
RE: Changes in Screening Procedures for Members Aged 60 or Older

Background

MassHealth has required home health agencies to obtain approval from an Aging Services Access Points (ASAP), before providing part-time or intermittent skilled nursing and home health aide services to those members aged 60 or older, in accordance with 130 CMR 403.411.

Change in Requirement

Effective December 1, 2006, MassHealth will no longer require home health agencies to complete a MassHealth Home Health Screening Request form and obtain approval from an ASAP before providing part-time or intermittent skilled nursing and home health aide services to those members aged 60 or older. The following forms will be obsoleted as a result of this change:

- MassHealth Home Health Screening Request [HHA-002 (01/98)]
 - MassHealth Skilled Nursing/Home Health Aide Service Increase Notification [HHA-003 (01/98)]
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ASAP Referral Form

Effective December 1, 2006, home health agencies must complete an **ASAP Referral** form for those MassHealth members aged 60 or older who could benefit from ASAP services. Home health agencies should forward the completed referral form to the member's local ASAP whenever the agency determines a MassHealth member could benefit from ASAP services and the member consents to a referral. A referral may occur upon assessment or reassessment for home health services or upon discharge from home health services, depending on the member's needs. A copy of the completed ASAP Referral form must be kept in the member's record.

If a home health agency determines that a member aged 60 or older should not be referred, the home health agency must complete only Sections A and B on the ASAP Referral Form and keep the form in the member's record.

(continued on next page)

***Choosing the
Appropriate ASAP***

The member's location determines which ASAP should receive the ASAP Referral form. You will find a list and contact information for each ASAP in Appendix A of your provider manual, available at www.mass.gov/masshealth and www.800ageinfo.com.

Supplies of Forms

Attached to this bulletin is a sample ASAP Referral form (HHA-4). You can also download this form from the Web at www.mass.gov/masshealth. Once you are there, go to MassHealth Regulations and Other Publications/Provider Library/MassHealth Provider Forms.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.



Aging Services Access Point (ASAP) Referral Form

Instructions for MassHealth Providers

Home health agencies (HHAs) must refer MassHealth members aged 60 or older to their local ASAP if the member could benefit from services provided by an ASAP. The referral may occur during home health services, or upon discharge, depending on the member's needs. The member or the member's representative must consent and sign this referral form. A completed copy of this form must be kept in the member's home health record.

If an HHA determines that a member does not require ASAP services, the HHA must complete Sections A and B only.

Section A (Required)

Home Health Agency (HHA) Information	
HHA Name:	HHA Telephone No.:
HHA Nurse or Therapist (print name):	Date of Referral:
HHA Nurse or Therapist (signature):	

Section B (Required)

MassHealth Member Information	
Name:	Telephone No.:
Is member appropriate for ASAP services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section C

Attach current Center for Medicare and Medicaid Services form 485 to this referral form, and explain how this member can benefit from ASAP services.	
.....	
.....	
Name of ASAP: _____	
Member's primary spoken language is: _____	
Does member require assistance with activities of daily living?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does member require assistance with instrumental activities of daily living?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section D (Member consent required for referral to be made)

Member Consent	
The home health agency (HHA) described to me the services provided by an ASAP. I understand that I can decide if I want the HHA to make a referral to my local ASAP. If I agree that I want a referral, then someone from the ASAP will contact me and assess whether I could benefit from ASAP services. If I do not want a referral, then no referral will be made and this form will be kept in my record with the HHA.	
Check one of the boxes below:	
<input type="checkbox"/> I want the home health agency to make a referral for me to the ASAP.	
<input type="checkbox"/> I do not want the home health agency to make a referral for me to the ASAP.	
Member or member's representative signature:	Date: