

ASSISTED LIVING SERVICES MANUAL



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ASSISTED LIVING SERVICE MANUAL

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Glossary

"Access Agency" is an organization which assists individuals to receive home and community based services by conducting universal assessments and developing plans of care tailored to the needs of the individuals, and making arrangements with service providers.

"Activities of daily living" means activities or tasks that are essential for a person's healthful and safe existence, including, but not limited to, bathing, dressing, grooming, eating, meal preparation, shopping, housekeeping, transfers, bowel and bladder care, laundry, communication, self-administration of medication and ambulation.

"Applied income" is the amount of gross income that remains after deducting certain costs.

Ascend www.ascendami.com

Through this site, the applicant can submit referrals to the Connecticut Home Care Program for Elders and track progress of individuals currently in the system.

"Assessment" means a comprehensive written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment and related service needs. For the purposes of the Connecticut Home Care Program for Elders, this assessment shall include a face-to face interview and shall utilize a standard assessment tool approved by the department.

"Assisted Living Services Agency" (ALSA) is an institution that provides, among other things, nursing services and assistance with ADLs to a population that is chronic and stable. Assisted living services are a special combination of housing, supportive services, core services, personalized assistance and health care designed to respond to the individual needs of those who require assistance with activities of daily living and instrumental activities of daily living. These services are necessary to enable the eligible clients to remain independent longer, thereby avoiding unnecessary or early transfer to a higher level-of-care facility.

"Connecticut Home Care Program for Elders" (CHCPE) helps eligible clients to live at home instead of going to a nursing home. The purpose of the Connecticut Home Care Program is to assess whether cost-effective home care services can be offered to elders who

are at risk of institutionalization, provide a full range of home care services to eligible individuals who choose to remain in the community, if such services are appropriate,

"Fee-for-service" means a service delivery system which a cost-and-payment methodology is used for services rendered to care-managed and self-directed clients who receive benefits under the Medicaid waiver or state- funded portions of the program, except those services rendered to clients participating in the assisted living services component of the program.

"Managed Residential Community" (MRC) is a facility with private residential units that provides a managed group living environment consisting of housing and services for persons who are primarily fifty-five years of age or older. "Managed residential community" does not include any state-funded congregate housing facilities.

"Personal care services" include, but are not limited to, hands-on assistance with daily activities, including but not limited to, dressing, grooming, bathing, using the toilet, transferring, walking and eating. Personal care services may also include personal laundry and changing bed linens in conjunction with incontinence care or other needs which necessitate such assistance more than once per week.

"Plan of care" means a written individualized plan of home care services which specifies the type and frequency of all services and funding sources required to maintain the individual in the community, the names of the service providers and the cost of services, regardless of whether or not there is an actual charge for the service. The plan of care shall include any in-kind services and any services paid for by the client or the client's representative;

Policies and Procedures

This manual provides comprehensive procedures, policies, requirements and responsibilities for Assisted Living Service Agencies.

Referrals

Applicants should use one of the following methods to make a referral and be placed on the wait list:

- Online at www.ascendami.com
- Call the referral line at 860-424-4904 or 1-800-445-5394, option 4
- Paper referral form. Use of paper forms is discouraged.

Depending on the applicant's income and assets, program participants may be required to pay a cost share or applied income. Cost share and applied income payments are mandatory and required. As of 7/2020, the cost share amount is 9% of paid claims for that month. For example, if there were \$1,000 of paid claims, the cost share amount would be \$90. Due to the different number of days in the month, the amount will be slightly different every month.

Application, Screening Process and Initial Assessment

Community Options clinical staff perform a health screen to determine if the resident meets functional eligibility criteria for the Connecticut Home Care Program for Elders. Referrals can be made for residents who are over the asset limit if they intend to spend down their assets. The resident can be placed in a waiting status. Community Options should be contacted once the resident has spent down to complete the referral and assessment process.

Initial Assessment

Applicants who appear to be eligible will be referred for an initial assessment conducted by one of the Access Agencies. Individuals may refuse the assessment and/or decide that they do not choose to receive services. The Access Agency uploads the Outcome Form (summary of initial assessment) to Ascend.

Assessments and Reassessments

The Access Agency will perform the initial assessment to determine level of need.

The Access Agency, assigned to the region of the assisted living facility, will conduct annual reassessments, based on the original assessment date. Issues related to the health, well-being and safety of participants are shared with the Access Agency care manager during the assessment.

Services

There are four Services Package Levels:

Occasional Personal Service

1 hour per week, up to 3.75 hours per week of personal services plus nursing visits as needed.

Limited Personal Service

4 hours per week, up to 8.75 hours per week of personal services plus nursing visits as needed.

Moderate Personal Service

9 hours per week, up to 14.75 hours per week of personal services plus nursing visits as needed.

Extensive Personal Services

15 hours per week, up to 25 hours per week of personal services plus nursing visits as needed.

Personal services include hands-on assistance with activities of daily living including, but not limited to, dressing, bathing, grooming, using the toilet, transferring, walking and eating. Services may include changing bed linens and incontinence care. Personal services are to be provided according to the participants' personal service level on the plan of care.

Nursing visits are to be provided on an as needed basis. It is required that the ALSA provide nursing visits as indicated in the participants' plan of care.

Service Package Level

The ALSA is required to assign a service package level. The ALSA is paid a per diem rate for each service package.

Change of Service Level

The ALSA may change a participant's service package at any time. The ALSA must justify and document the need for the change based on the participant's needs. The DSS

Quality Assurance Team audits include assessing the service package and evaluation of the documentation to support the change.

Procedure codes and rates can be found at www.ctdssmap.com under Provider.

Required Forms for Applicant Program Participation

- The W-950 DSS "Delay Notice" to be used by the Access Agency and ALSA to notify Community Options delay of assessment, reassessment, and implementation of plan of care.
- The W-1527 DSS "Outcome Form" to be used by the Access Agency and ALSA to indicate client's initial assessment, reassessment, status review, or re-evaluation, based on DSS policies and procedures.
- The W-1510, DSS "Plan of Care" to be used by the Access Agency and ALSA to indicate the type of services, frequency and cost of care for client.
- The W-1511, DSS "Assisted Living Cost Worksheet" to be used only by the ALSA to determine the DSS client's assisted living service package and cost, and additional core services, mental health, or ERS, if applicable.
- The W-1523 DSS "Applied Income Worksheet" to be used by the Access Agency and ALSA for the calculation of the client's applied income and final review and determination by Community Options.
- The W-1514 DSS "Applied Income Agreement" to be used by the Access Agency and ALSA to obtain the client's or client's representative signature and agreement to pay the mandatory client contribution, if applicable.

Approval to start services is entered as a memo in Ascend with the date that the client is determined eligible and services may begin.

The time frames are to be followed to ensure that the assisted living services can start as soon as possible and to avoid any delays. If there are any problems or extenuating circumstances that will cause a delay, the ALSA must contact Community Options immediately via telephone and also provide the reasons in writing using a delay notice. DSS/Community Options will review the information provided by the ALSA and will

provide any feedback. The allowed delays are as follows: the client is out of the facility for less than ten days for personal reasons or is hospitalized.

DSS/Community Options reviews the documents received from the ALSA and enters a memo in Ascend indicating the final approval to the ALSA. Once the approval is received by the ALSA, the ALSA can start the assisted living services. If the client is determined to have to contribute towards their cost of care, the ALSA obtain a signed "Client Applied Income Agreement". The client's applied income be collected by the MRC or the ALSA. The applied income amount is the final determination calculated by Community Options on the W-1523. If the MRC collect the client's applied income, the MRC is responsible for ensuring that the ALSA receives the client's payments. However, it is the responsibility of the ALSA to ensure that the collection is taking place and to follow the DSS client non-payment process, if applicable.

For active DSS/CHCPE clients receiving services through the CHCPE fee for service delivery system and now choose assisted living services, the MRC, ALSA, or the Access Agency must contact Community Options for approval. DSS/Community Options notifies the Access Agency via a memo in Ascend that the client is requesting the assisted living component. The Access Agency forward to Community Options copies of the following information:

- Informed Consent Form
- current plan of care, cost worksheet,
- most current assessment,
- outcome form, and
- client's current applied income agreement, if applicable.

Once Community Options receives the information requested from the Access Agency, Community Options sends copies of all the above documentation to the ALSA requesting that the client be processed for assisted living services. The ALSA sends Community Options within seven (7) days copies of the following paperwork: plan of care, cost worksheet, and Applied Income Worksheet (if applicable). DSS/Community Options reviews the documentation and issues a determination. If assisted living services are approved by Community Options, Community Options forwards the approval to the ALSA via a memo in Ascend and a copy to the Access Agency. The Access Agency and ALSA must coordinate and establish a transfer date and start date for the assisted living services. The ALSA must coordinate the transfer date with the Access Agency. The Access Agency informs Community Options of the agreed transfer date via a memo in Ascend and forward a copy to the ALSA. DSS/Community Options

enters a memo in Ascend to the ALSA approving the start of assisted living services with the effective date of transfer.

For active CHCPE self-directed care clients that reside in approved MRCs, the process established must be followed to process these CHCPE clients for the DSS assisted living service component. The CHCPE self-directed program is being phased out.

Transfer of Participants to Fee-For-Service

Participants may decide to transfer to fee-for-service delivery system. The ALSA must send the request to DSS Community Options clinical staff by entering a memo in Ascend. Once a participant is approved to return to fee-for-service, the Access Agency is responsible for coordinating the transfer.

Denial of Program Participation or Service from DSS/CHCPE or DECD Program

If a resident:

- Is determined ineligible for program participation, DSS/Community Options or the MRC will notify the individual in writing. The resident has the right to appeal the decision through a fair hearing or grievance process.
- Was denied DSS/CHCPE, he or she may appeal the decision through the DSS Administrative Hearings Division. If the MRC or ALSA rendered the denial, the resident can appeal the decision in writing, through the MRC grievance process in writing. If the resident requests an Administrative Hearing or follows the grievance process, the resident is not entitled to receive services pending the decision. If the resident is upheld, then compliance with the decision is required. If the resident is not upheld, no further action is required and the resident will not receive services.
- Is an active client under either the DSS/CHCPE or DECD program and is denied services (e.g. increase of services, etc.) the ALSA must try to resolve the concern or issue through negotiation with the client. If these negotiations are successful, the ALSA will document in their progress notes what transpired and the ultimate decisions reached.

For CHCPE clients, if the issue cannot be resolved by the ALSA at that level, the client has the right to request that DSS/Community Options review the issue and the decision. If the client is not satisfied with the outcome of the DSS review, the client may appeal the decision through the Department's Administrative Hearing process. Individuals who have been denied services or have had services reduced can write to the Office of Legal

Counsel, Regulations and Administrative Hearings, DSS, 55 Farmington Ave., Hartford, CT 06105.

For DECD Program clients, if the issue cannot be resolved at that level, the client has the right to request that the MRC designee review the issue and the decision. If the client is not satisfied with the outcome of the MRC designee, the client may follow the grievance procedures.

Private Assisted Living Program

Overview

Public Act 02-7 authorized the State of Connecticut Department of Social Services, within available appropriations, to establish a Private Assisted Living Program. The Act allows qualified participants to receive assisted living services through the Medicaid Waiver under the Connecticut Home Care Program for Elders through the collaborative effort of the Office of Policy and Management, the Department of Public Health and the Department of Social Services.

The program grew out of recognition that some elders, after living in a Private Assisted Living Facility for a time, have spent down their assets and thus require help paying for home care services. It provides help paying for home care services for persons age 65 and older who reside in approved private assisted living communities, and who qualify functionally and financially for the CHCPE.

The Private Assisted Living Program is an opportunity for many who need assistance with activities of daily living. The program provides funding for their assisted living services but does not pay for room and board. This program is based on the premise that it is cost effective to provide these services so these participants will not require care in a nursing facility.

Referral Information

There are 125 slots available. When no slots are available, applicants are placed on a waiting list. Applicants should use one of the following methods to make a referral and be placed on the wait list:

- Online at www.ascendami.com
- Call the referral line at 860-424-4904 or 1-800-445-5394 , option 4
- Paper referral form. Use of paper forms is discouraged.

Depending on the applicant's income and assets, program participants may be required to pay cost share or applied income. Cost share and applied income payments are mandatory and required.

Once the applicant is determined eligible and the applicant has been offered a slot on the program, an Access Agency care manager will contact the applicant to conduct a needs assessment. The applicant, the assisted living staff and the Access Agency develop a plan of care and determine the applicant's Service Package Level based on the needs assessment. Service Package Levels are based on weekly hours of personal care services needed by the applicant.

Service Package Level

The ALSA is required to assign as service package level. The ALSA is paid a per diem rate for each service package.

Change of Service Level

The ALSA may change a participant's service package at any time. The ALSA must justify and document the need for the change based on the participant's needs. The DSS Quality Assurance Team audits include assessing service package and evaluation of documentation to support the change.

Procedure codes and rates can be found at www.ctdssmap.com under Provider.

Application, Screening Process and Initial Assessment

Community Options clinical staff perform a health screen to determine if the resident meets functional eligibility criteria for the Connecticut Home Care Program for Elders. Referrals can be made for residents who are over the asset limit if they intend to spend down their assets. The resident can be placed in a waiting status. Community Options should be contacted once the resident has spent down to complete the referral and assessment process.

Initial Assessment

Applicants who appear to be eligible will be referred for an initial assessment conducted by one of the Access Agencies. Individuals may refuse the assessment and/or decide that they do not choose to receive services. The Outcome Form (summary of initial assessment) is uploaded to Ascend.

Adjustments in Reimbursement to the ALSA

The Department will reduce its reimbursement to the ALSA for Assisted Living Services by the amount of the designated client applied income contribution. The client's applied income contribution is applied to the cost of all Assisted Living Services (personal services and core services), and is deducted from the claims as they are submitted by the ALSA to DXC.

Required Forms for Applicant Program Participation

Required Forms

- The W-1510, DSS "Plan of Care" is used by the Access Agency and ALSA to indicate the type of services, frequency and cost of services for the client. Client/authorized representative and provider signature are required.
- The W-1511, DSS "Assisted Living Cost Worksheet" will be used only by the ALSA to determine the DSS client's assisted living service package.
- The W-1523 DSS "Applied Income Worksheet" will be used by the Access Agency and ALSA for the calculation of the client's applied income.

Approval to start services will be entered as a memo in Ascend with the date that the client is determined eligible and services may begin.

Program Eligibility

To qualify the applicant:

- Must be age 65 or older
- Must qualify functionally (require assistance with activities of daily living) and qualify financially for Connecticut Home Care Program for Elders (CHCPE).
- Must reside in a participating Managed Residential Community (MRC) served by a participating Assisted Living Service Agency (ALSA).
- Must complete a W1-LTC application and submit all of the required financial verifications.

This information describes some of the rules for applying for both the Medicaid and State Funded portions of the Connecticut Homecare Program for Elders. The complete rules are in the Department of Social Services Uniform Policy Manual found at <https://portal.ct.gov/DSS/Lists/Uniform-Policy-Manual>. Applications can be found at our website along with directions on how and where to submit them at <https://portal.ct.gov/DSS/Health-And-Home-Care/Long-Term-Care/Apply>.

- To apply, complete and sign an application. The application requires complete and detailed information about finances. Applicants need to verify

financial information. DSS will send a list of necessary documents to verify financial eligibility which must be submitted by the due date.

- Individuals applying for Medicaid should submit their applications to the Community Options Medicaid Waiver Application Unit. This unit is a part of the DSS Greater Hartford office at 20 Meadow Road in Windsor, CT 06095
- State-Funded applications are submitted to the Community Options State-funded unit via the Ascend system

To be eligible the applicant must:

- be a United States citizen or an eligible non-citizen,
- be a Connecticut resident
- be at least 65 years old
- have a limited amount of income and assets
- Require nursing home level of care

Income

- The gross income limit for the Medicaid portion of CHCPE is equal to 300% of the SSI standard. This is \$2,249.00 as of 01/01/2020. (These amounts change yearly. Reference the DSS Community Options webpage for current amounts.)
- If an individual is over the Medicaid income limit the only way they can qualify for the Medicaid Waiver is to establish a pooled trust.
- There is no income limit for the State-Funded portion of the program
- Examples of countable income: wages, Social Security benefits, pensions and veteran's benefits.

Assets

- Examples of assets: bank accounts, stocks, bonds, trusts, annuities, property and life insurance.
- The State-Funded asset limit is \$38,592.00 for a single individual and \$51,456.00 for a married individual
- The Medicaid asset limit is \$1600.00 for an individual.
- If a Medicaid applicant has a spouse who lives in the community, part of the spouse's combined assets can be protected. DSS does not count the value of the protected assets when determining eligibility. First, DSS adds the applicant and the spouse's total countable assets as of the initial date that the applicant was admitted to a hospital or long-term care facility and had a continuous stay of 30 days or more. This is called the date of institutionalization. DSS determines the date that through a medical determination as the date of institutionalization. DSS divides the total in half

to determine the "spousal share". The amount that can be protected is called the "Community Spouse Protected Amount" or "CSPA". The minimum and maximum amounts are set by federal law and the state is required to update the amounts yearly. The CSPA cannot exceed the maximum amount, except by a Fair Hearing decision or through a court order. When the applicant and spouse have assets that are more than the CSPA plus the \$1600 Medicaid asset limit, the excess assets are considered available to the applicant. This is true regardless of which spouse owns the assets. The applicant is not eligible for Medicaid until the applicant and the spouse's combined assets are reduced to the total of the \$1,600 asset limit plus the CSPA. The applicant and the spouse may reduce the assets total by paying medical expenses. However, as long as fair market value is received, the excess assets may be spent on what either spouse needs.

- The following assets do not count towards the \$1,600 asset limit.
 - The equity value of the applicant's home as long as:
 - the applicant is living there
 - the spouse is living there
 - a dependent child under the age of 21 is living there
 - a child with a disability lives there
 - if the applicant is expected to return home
 - in some cases, if a brother or sister live there
 - Term-life insurance that has no cash surrender value.
 - Ordinary household goods and personal effects.
 - One car owned by either the applicant or the spouse.
 - DSS may or may not count whole life insurance policies as an asset.
 - DSS looks at the face value of these policies to decide if they have to be counted. DSS adds the face value of the policies together and if the total amount of the policies is \$1,500 or less, DSS does not count them as an asset. If the total is more than \$1,500, applicants must verify the cash surrender values of each policy and DSS will count the cash surrender values of the policies as an asset.
 - DSS excludes any life insurance policies that have cash value \$10,000 or less, as long as it is in the process of being surrendered and documented appropriately.
 - The applicant can have an irrevocable funeral contract with a Connecticut funeral home that is valued up to \$10,000.00 or with a funeral home outside of Connecticut (subject to the laws of that state).

- The applicant can have a separate contract for burial space items which include the purchase of a burial plot, opening and closing of a grave site, cremation urn, casket, outer burial container and a headstone or marker.
- Assets over the limit may be used in several ways, as long as they are not given away or exchanged for something of lesser value. For example, the applicant may use the applicant assets over the limit to pay for the cost of the applicant care in the assisted living or at home, to pay other bills that the applicant have, or to prepay the applicant's funeral expenses.
- The full value of any accounts with the applicant's name on it is presumed to belong to the applicant, unless the other owner(s) can document that some or all of the funds are his or hers.

Transfer of Assets

- If the applicant apply for Medicaid or State-funded CHCPE to pay for the applicant care in an assisted living, we look to see if the applicant or the spouse gave away any assets in the 60 months before the applicant apply for help. We call this the "look-back period". There is no penalty if the applicant sell the applicant's assets for fair market value. However, if the applicant transfer assets for less than fair-market value to someone other than the spouse or a blind or disabled child or certain others described in DSS regulations, there will be a penalty period when the applicant is ineligible for payment of services.

It is expected that the MRC will assist the resident with completing the W1LTC.

<https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Long-Term-Care/w-1ltc.pdf?la=en>

Eligible residents have the option to accept the Private Assisted Living Program or choose fee-for-service and care management from one of the Access Agencies.

Depending on the client's income, clients may be required to contribute to their cost of services under the CHCPE. This contribution is in addition to any fees that a client payable to the MRC.

The ALSA is responsible to ensure the collection of the required and mandatory DSS client applied income contribution. The ALSA can make arrangements with the MRC to collect the client contribution. The following are the DSS Applied income forms: DSS Applied Income Worksheet (W-1523) and DSS Client Applied Income Contribution Agreement (W-1514).

Client Applied Income Procedures

The client applied income contribution is a mandatory/required payment that a client or responsible party must pay. This applied to both Medicaid and State-funded consumers. There are no exceptions or waivers to this policy. It is essential that the process of collection and non-payment, as described in this Manual, be followed.

Applied Income is the program participant's portion of income that is put towards the cost of their care, paid to the ALSA. Applied Income is calculated by subtracting the Personal Needs Allowance and other approved deductions from the gross unearned income.

When the ALSA calculates that an applied income is required (State-Funded client), DSS determines the final calculation. The ALSA must then obtain a new agreement.

When the DSS Regional Office provides information concerning a Medicaid Waiver client, indicating that there has been an applied income determination, the ALSA must then obtain a new agreement and collect the applied income amount. The amount determined by the DSS Regional Office is the client's mandatory applied income contribution to his/her cost of services. DSS will notify the ALSA of the applied income amount, if applicable.

The individual is allowed to protect an amount equal to 200% of the individual poverty level and other allowable deductions such the Medicare premium and other health insurance premiums. An individual with an income at or below that amount, who is under the CHCPE Medicaid Waiver program, will have no contribution.

The "State-Funded Applied Income Worksheet" (W-1523) is updated every year by DSS with revised amounts. The effective date for updating the worksheet is April 1st of each year and, on an as needed basis for policy and regulation compliance.

The ALSA is responsible to obtain the required information and complete the designated sections in the "Applied Income Worksheet" for each CHCPE State-Funded client receiving Assisted Living Services under the Demonstration Project. The ALSA uploads the document in Ascend. DSS calculates the final amount of the applied income and enters a memo in Ascend.

Applied Income Re-Calculation

The amount of an individual's applied income contribution is recalculated annually when financial eligibility is redetermined. Other than the annual review, recalculations are only

done on a case by case basis. The ALSA/MRC may request a recalculation due to changes in the resident's income. The ALSA/MRC is responsible for determining and verifying either additional or less applied income based on the current financial status.

Legally Liable Relative Determination

The spouse of a resident may be required to contribute toward the cost of care. DSS may request payment towards the cost of services when the contribution will not result in the community spouse to fall below the Minimum Monthly Needs Allowance (MMNA). The ALSA is responsible for the completion of the W-850 "Legally Liable Relative form. The ALSA must retain the original form in the resident's record.

Client Refusal to Pay the Mandatory Applied Income Contribution and/or 9% Cost Share

If a client refuses to pay the Applied Income Contribution Agreement and/or the 9% cost share, the ALSA must obtain a written statement from the client to this effect. Subsequently, the client will not be eligible to receive CHCPE Assisted Living Services. It is at the discretion of the MRC if the client can remain at the MRC.

DSS will forward a denial or discontinuance of services letter to the client based on the client's non-cooperation with CHCPE program requirements. If the ALSA fails to follow DSS procedures for collecting the client applied income and/or cost share contribution, then DSS is not responsible or obligated to compensate for any loss of revenue.

Adjustments in Reimbursement to the ALSA

The Department will reduce its reimbursement to the ALSA for Assisted Living Services by the amount of the designated client applied income contribution and/or cost share.. The client's applied income contribution and/or 9% cost share is applied to the cost of all Assisted Living Services (personal services and core services), and is deducted from claims submitted to DXC. The ALSA may charge the resident for the cost share amount.

Financial Renewals

(previously known as redeterminations)

DSS is responsible for conducting the annual financial renewal for clients on the program. DSS will issue the results of the renewal and report any changes to the applied income amount.

The ALSA/MRC is responsible for providing and helping the client fill out the W1-LTC.

Assisted Living Demonstration Project

The State Department of Social Services (DSS), in collaboration with the State Department of Public Health (DPH), State Department of Economic and Community Development (DECD) and the Connecticut Housing Finance Authority (CHFA), established a demonstration project to provide subsidized assisted living services, as defined in section 19-13-D105 of the regulations of Connecticut state agencies, for persons residing in affordable housing, as defined in section 8-39a. The demonstration project is limited to a maximum of (300) three hundred subsidized dwelling units. Applicants for such subsidized Assisted Living Services are subject to the same eligibility requirements as the Connecticut Home Care Program for Elders (CHCPE) pursuant to section 17b-342.

Qualified individuals may be able to receive assisted living services through a licensed service agency (ALSA) under contract with the MRC. Payment for services are reimbursed according to the rates on file. Persons who require additional assistance may choose to pay for services privately. The ALSA submits claims for payment through the DXC claim processing system. Qualified individuals may be able to access affordable housing through a rental subsidy with the CHFA. Individuals will have to meet the CHCPE technical, financial and functional criteria, and qualify for the rental subsidy as established by the MRC to qualify for participation in the Demonstration Project. Clients who are already on the Connecticut Home Care Program for Elders may keep these services until the ALSA services start. Participants in Demonstration Project assisted living program may not receive these services while residing at one of the Demonstration Project assisted living facilities. The CHCPE fee for service component will stop. Participants cannot receive fee for service, care management services while in the MRC under the Demonstration Project.

The MRC will be responsible for maintaining and administering the list of interested individuals for the Demonstration Project including all procedures relative to the list. Applicants or active clients under the CHCPE may request to have their names placed on the MRC's list. The MRC will notify DSS /Community Options when there is a demonstration unit available and an applicant or active client's name has been reached on the list. Determination for the rental subsidy will be initiated by the MRC at the time

of referral to DSS/Community Options. Having the name placed on the MRC's list does not guarantee a demonstration unit nor that services will be available or offered unless the individuals on the list are determined to qualify for subsidized housing and assisting living services.

Once an individual is determined eligible by both the MRC and DSS/Community Options, the client may choose to participate as an active Demonstration Project client enabling him/her to receive the rental subsidy and assisted living services. The client may have to contribute towards the cost of his/her services and rental fee depending on the client's gross amount of income. The contribution towards the cost of services and rental subsidy will be based on a standardized table established by DSS and CHFA.

For active CHCPE clients who are receiving services through the CHCPE fee for service delivery system and request consideration for the services under the Demonstration Project, the ALSA or the Access Agency must contact DSS. DSS will notify the Access Agency via a memo in Ascend the client's request for consideration for the Demonstration Project, after DSS verifies that the client has been determined qualified under MRC rules and a demonstration unit is available.

The Access Agency and ALSA must coordinate and establish a transfer date. The Access Agency will inform DSS of the agreed transfer date via a memo in Ascend and DSS will approve the start of Assisted Living Services under the Demonstration Project, with the effective date of the transfer.

State-Funded Congregate and HUD Facilities

Public Act 00-2 allows the Department of Economic and Community Development (DECD) to offer assisted living services to residents in state-Congregate Housing and HUD Facilities. Through the collaborative effort of DECD, the Department of Public Health (DPH) and the Department of Social Services (DSS), the program went into effect October 1, 2000. Public Act 00-2 also grants Managed Residential Community (MRC) status to approved state-funded housing and HUD facilities for the purpose of providing assisted living services and allows DPH to waive provisions of the ALSA regulations on a case by case basis. In addition, the program provides some enhanced services to all residents living in approved state-funded Congregate Housing and HUD facilities, regardless of whether they need assisted living services, to enable these residents to remain independent longer, thereby avoiding unnecessary or early transfer to a higher level of care facility. To accomplish this, the state-funded congregate and HUD facilities operating subsidy programs have been enlarged in scope to include expanded core

services. These expanded core services include a resident services coordinator (RSC), a wellness/prevention program, and emergency transportation.

The MRC is responsible for informing all residents that Assisted Living Services are available under the DSS/CHCPE and DECD Program. Information may be posted in common areas used by residents, on bulletin boards, or be given individually to each resident/caregiver/representative.

Discontinuances

A memo must be entered in Ascend to notify Community Options that the client is no longer there.

Discontinuation Reasons:

- Expired
- Hospital stay exceeds program limits
- Become financially ineligible (over income and/or assets)
- Moved
- Care needs exceed program limits Transfer to CHCPE care management
- Placement in nursing home
- Non-compliance with financial contributions (cost share and applied income)

PROVIDER REQUIREMENTS

Assisted Living Services Agency (ALSA)

Assisted Living Services Agencies must:

- Be licensed by the State Department of Public Health and adhere to DPH licensure requirements including an unpaid assessment of clients.
- Enter into an agreement with the MRC at the facility.
- Must sign a Provider Agreement with DSS.
- The ALSA must adhere to the DPH licensure requirements including, but not limited to, performing their own unpaid assessments of clients, regardless of whether the initial assessment is performed by another entity or contracted state agency. The unpaid assessment, required by licensure, is not for the purpose of determining CHCPE program eligibility.
- The ALSA must provide to DSS and the MRC, verbal notice followed by immediate written advance notice thirty (30) days prior to the intent to terminate its contract as the ALSA in a specific facility or as an ALSA performing provider. If the ALSA decides to re-enroll, the process will start over using the same procedures as the first provider enrollment.
- The ALSA that terminates the contract cannot bill or be reimbursed for services rendered to DSS clients after the ALSA services are discontinued. The ALSA's provider number and enrollment is end dated with DXC and DSS.

Relationship between the Private Assisted Living Facility (MRC) and the ALSA

The MRC will continue to provide the required services as described in the DPH regulation for MRCs. The MRC, through the ALSA, may make arrangements to provide for additional housekeeping, laundry service or preparation of meals under core services.

DXC Technology

The ctdssmap.com website is provided by DXC Technology on behalf of the Department of Social Services. This site contains a wealth of resources for providers including

enrollment, billing manuals, bulletins, program regulations, plus information on Electronic Data Interchange and the Automated Eligibility Verification System

Provider Enrollment

The DXC Technology Provider Enrollment Wizard is available to providers newly enrolling in the program and those providers who are notified that it is time for re-enrollment into the program. This Wizard offers a simplified, expedited method of enrollment/re-enrollment.

The Provider Enrollment Unit is responsible for processing the enrollment and re-enrollment applications submitted by providers. Enrollment and re-enrollment must be completed on-line via the Web portal Enrollment Wizard at www.ctdssmap.com. DXC Technology is the primary source for responding to provider questions on various aspects of the Connecticut Medical Assistance Program. The Provider Enrollment Unit forwards accepted applications to the Department of Social Services Quality Assurance for final approval.

Provider Assistance Center

DXC Technology responds to questions on client and provider eligibility, claim submission procedures, claims processing issues and provider enrollment. Questions on these topics should be directed to the Provider Assistance Center. The Provider Assistance Center is the provider's source for information not provided on the Web portal or from the Automated Voice Response System (AVRS).

Customer service representatives are available from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding holidays, by calling toll free at 1-800-842-8440.

EDI Help Desk

The Electronic Data Interchange (EDI) Unit answers questions regarding the HIPAA Electronic Transactions, DXC Technology Provider Electronic Solution (PES) software, and electronic claims submission. Contact the EDI Help Desk toll free at 1-800-688-0503, Monday through Friday, 8:00 a.m. to 5:00 p.m., excluding holidays.

Ctdssmap.com Publications

By clicking on "Information" and clicking on "Publications", providers can access the Provider Manual, Provider Bulletins and Important Messages.

Community Options Quality Assurance

Community Options staff conduct audits of assisted living service providers on a rotating basis. If there are new staff at the facility, Quality Assurance staff may conduct

an audit for the purposes of teaching the policies and procedures. Findings are intended to provide assistance and recommendations for improvement.

Quality Assurance staff are available for assistance and questions.

Following is the criteria for client files and items in the client that are being evaluated for the audit.

CLIENT RECORD REVIEW ITEMS		
RECORD REVIEW COMPLIANCE ITEM	STATE REGULATIONS = STATE REGULATION 19-13-D105	
	SECTION = CURRENT CHCPE ASSISTED LIVING MANUAL	
1. CLIENT FACE SHEET	STATE REGULATIONS, PG A8-9, A11, A13-14 ADDRESSES CLIENT RECORD REQUIREMENTS – DPH ENFORCEMENT	
2. GOAL & ELIGIBILITY CHECKLIST		
A. CLIENT CENTERED		
B. MEASURABLE		
OUTCOMES DOCUMENTED		
3. PROGRESS NOTES		
4. FINANCIAL APPLICATION (W1LTC)	SECTION 9.1, B1	THE ALSA IS RESPONSIBLE FOR PROVIDING AND ASSISTING DSS/CHCPE STATE-FUNDED CLIENTS WITH THE COMPLETION OF THE W1LTC. THE ALSA IS TO FORWARD A COMPLETED COPY OF THE W1LTC TO Community Options. FOR THE DSS CHCPE MEDICAID WAIVER CLIENT, THE DSS/RO WILL FORWARD THE W1LTC TO THE CLIENT... THE ALSA IS EXPECTED TO ASSIST THE CLIENT. ... THE ALSA MUST RETAIN A COPY OF THE W1LTC IN THEIR CLIENT FILES. (REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE W1LTC (FOR STATE-FUNDED CLIENTS)...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES. THE ALSA IS TO PROVIDE A W1LTC TO STATE FUNDED CLIENTS AT THE TIME OF THEIR ANNUAL REASSESSMENT. TO ASSURE TIMELY COMPLIANCE AND CONTINUED PARTICIPATION IN THE DSS/CHCPE, THE ALSA IS TO ASSIST THE CLIENT WITH THE COMPLETION OF THE W1LTC.
	SECTION 9.1, B5	
	SECTION 11.1B	
	SECTION 11.1C	

<p>5. SIGNED CLIENT FEE AGREEMENT (W1514)</p>	<p>SECTION 3.4, C</p> <p>SECTION 3.6, C3</p> <p>SECTION 7.2, B1</p> <p>SECTION 7.2, B2</p> <p>SECTION 9.1, B3</p> <p>SECTION 9.1, B5</p>	<p>"APPLIED INCOME AGREEMENT" TO BE USED BY THE AA AND ALSA TO OBTAIN THE CLIENT'S OR CLIENT REPRESENTATIVE'S SIGNATURE AND AGREEMENT TO PAY THE MANDATORY CLIENT CONTRIBUTION, IF APPLICABLE.</p> <p>IF THE CLIENT IS DETERMINED TO HAVE TO CONTRIBUTE TOWARDS THEIR COST OF CARE, THE ALSA IS TO OBTAIN A SIGNED "CLIENT FEE INCOME AGREEMENT".</p> <p>IN THE FOLLOWING ASSISTED LIVING SERVICES CASES A NEW "CLIENT APPLIED INCOME CONTRIBUTION AGREEMENT" IS REQUIRED: (1) WHEN THE ALSA CALCULATES THAT AN APPLIED INCOME IS REQUIRED (STATE-FUNDED CLIENT) AND Community Options DETERMINES THE FINAL CALCULATION THEN THE ALSA MUST OBTAIN A NEW AGREEMENT.</p> <p>N THE FOLLOWING ASSISTED LIVING SERVICES CASES A NEW "CLIENT APPLIED INCOME CONTRIBUTION AGREEMENT" IS REQUIRED; (2) WHEN THE DSS REGIONAL OFFICE PROVIDES Community Options STAFF WITH INFORMATION (REASSESSMENT) IF AT ANY TIME THERE ARE ANY CHANGES TO THE POC, COST OF CARE, OR CLIENT APPLIED INCOME CONTRIBUTION, THE ALSA MUST HAVE AN UPDATED ...CLIENT APPLIED INCOME CONTRIBUTION AGREEMENT IN THE CLIENT'S RECORD</p> <p>REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE APPLIED INCOME AGREEMENT...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.</p>
<p>6. COMPLETED & CURRENT APPLIED INCOME WORKSHEET (W1523)</p>	<p>SECTION 3.4, C</p> <p>SECTION 3.6, A1</p> <p>SECTION 9.1, B5</p>	<p>TO BE USED BY THE AA AND ALSA FOR THE CALCULATION OF THE CLIENT'S APPLIED INCOME AND FINAL REVIEW AND DETERMINATION BY Community Options.</p> <p>FOR THE DSS/CHCPE NON-ACTIVE CLIENTS/RESIDENTS DETERMINED ELIGIBLE AND WHO HAVE ACCEPTED ASSISTED LIVING SERVICES, THE ALSA MUST SUBMIT W/IN 7 WORKING DAYS TO Community Options THE FOLLOWING FORMS: APPLIED INCOME WORKSHEET (W1523)</p> <p>THE ALSA IS RESPONSIBLE TO OBTAIN THE REQUIRED INFORMATION AND COMPLETE THE DESIGNATED SECTIONS IN THE "APPLIED INCOME WORKSHEET" FOR EACH STATE-FUNDED CLIENT RECEIVING ASSISTED LIVING SERVICES.</p> <p>(REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE APPLIED INCOME WORKSHEET (IF APPLICABLE)...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.</p>
<p>7. SIGNED INFORMED CONSENT & ACCEPTANCE OF ASSESSMENT (W889)</p>	<p>SECTION 3.4, C</p>	<p>TO BE USED BY THE AA AND ALSA TO OBTAIN THE CLIENT'S CONSENT OR REFUSAL OF THE ASSESSMENT AND PROGRAM SERVICES.</p> <p>.</p>

8. SIGNED STATE AUTHORITY FOR RECOVERY (W997)	SECTION 3.4, C SECTION 3.4, C SECTION 3.6, A1	TO BE USED BY THE AA & ALSA TO INFORM THE CLIENT/REPRESENTATIVE OF THE STATE AUTHORITY TO RECOVER ANY FUNDS SPENT ON THEIR SERVICES – THIS FORM IS TO BE COMPLETED ONLY ONCE, AS LONG AS THE CLIENT REMAINS AN ACTIVE CLIENT ON THE DSS HOME CARE PROGRAM. THE ORIGINAL COPY IS TO BE RETAINED AT Community Options CLIENT RECORD. FOR THE DSS/CHCPE NON-ACTIVE CLIENTS/RESIDENTS DETERMINED ELIGIBLE AND WHO HAVE ACCEPTED ASSISTED LIVING SERVICES, THE ALSA MUST SUBMIT W/IN 7 WORKING DAYS TO Community Options THE FOLLOWING FORMS...W-997 (NOTICE OF STATE'S AUTHORITY FOR RECOVERY". W-997 "NOTICE OF STATE'S AUTHORITY FOR RECOVERY" WHICH NEDXC TO BE OBTAINED ONLY ONCE, AS LONG AS THE CLIENT IS AN ACTIVE DSS HOME CARE PROGRAM CLIENT.
9. SERVICE ORDERS	STATE REGULATIONS , PG A-13– DPH ENFORCEMENT	
10. PROVIDER REPORTS		
11. CHECKLIST TO AUTHORIZE CARE MGT		
12. COMPLETED LEGALLY LIABLE RELATIVE	SECTION 8.1, B SECTION 9.1, B5	THE ALSA IS RESPONSIBLE FOR THE COMPLETION OF THE W-850 "LEGALLY LIABLE RELATIVE FORM FOR SPOUSES OF CLIENTS RECEIVING MEDICAID HOME AND COMMUNITY BASED WAIVER SERVICES OR THE STATE-FUNDED CT HOME CARE PROGRAM FOR ELDERS. THE ALSA MUST RETAIN THE ORIGINAL FORM IN THE CLIENT'S RECORD. (REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE LLR (IF APPLICABLE)...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.
13. COMPLETED & CURRENT ASSISTED LIVING COST WORKSHEET (W1511)	SECTION 3.4, C SECTION 3.6, A1 SECTION 6.3,G SECTION 9.1, B3 SECTION 9.1, B5	TO BE USED ONLY BY THE ALSA TO DETERMINE THE DSS CLIENT'S ASSISTED LIVING SERVICE PACKAGE AND COST, AND ADDITIONAL CORE SERVICES, MENTAL HEALTH, OR ERS, IF APPLICABLE. FOR THE DSS/CHCPE NON-ACTIVE CLIENTS/RESIDENTS DETERMINED ELIGIBLE AND WHO HAVE ACCEPTED ASSISTED LIVING SERVICES, THE ALSA MUST SUBMIT W/IN 7 WORKING DAYS TO Community Options THE FOLLOWING FORMS: COST WORKSHEET (W1511) IT IS IMPORTANT THAT THE ALSA KEEP AN UPDATED POC AND COST WORKSHEET FOR EACH DSS CLIENT. THIS INFORMATION MUST BE MADE AVAILABLE TO THE DEPARTMENT UPON REQUEST. (REASSESSMENT) IF AT ANY TIME THERE ARE ANY CHANGES TO THE POC, COST OF CARE, OR CLIENT APPLIED INCOME CONTRIBUTION, THE ALSA MUST HAVE AN UPDATED ... COST WORKSHEET....IN THE CLIENT'S RECORD (REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE COST WORKSHEET...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.

14. INITIAL & CURRENT ASSESSMENT TOOL PRESENT (W1507A)	SECTION 3.4, C SECTION 9.1, A1 SECTION 9.1, B5	"MODIFIED ASSESSMENT TOOL" IS TO BE USED BY THE ALSA FOR ...THE DSS/CHCPE REASSESSMENT. THE ALSA IS TO USE THE DSS MODIFIED ASSESSMENT TOOL FOR THE ANNUAL REASSESSMENT OF CLIENT'S FUNCTIONAL ELIGIBILITY AND SERVICE NEDXC. (REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETE THE MODIFIED COMMUNITY CARE ASSESSMENT TOOL.... THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.
15. OUTCOME FORM PRESENT (W1527)	SECTION 3.4, C SECTION 9.1,B5	TO BE USED BY THE AA AND ALSA TO INDICATE CLIENT'S ASSESSMENT, REASSESSMENT OR STATUS REVIEW DETERMINATION. (REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE OUTCOME FORM...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.
16. ASSESSMENT PROFILE/PROBLEM LIST	STATE REGULATIONS , PG A13– DPH ENFORCEMENT	
17. CONTACT TO SCHEDULE ASSESSMENT W/IN 1 WORKING DAY OF THE REFERRAL	ACCESS AGENCY RESPONSIBILITY	
18. ASSESSMENT & PLAN OF CARE INITIATED W/IN 7 WORKING DAYS OF THE REFERRAL	ACCESS AGENCY RESPONSIBILITY- NO REFERENCE TO ASSESSMENT W/IN 7 WORKING DAYS	
	STATE REGULATIONS, PG A13 – DPH ENFORCEMENT: THE COMPLETE CLIENT SERVICE RECORD SHALL INCLUDEA CLIENT SERVICE PROGRAM...WITHIN 7 DAYS OF THE CLIENT'S ADMISSION TO THE AGENCY...	
19. NOTIFICATION OF DELAY OF ASSESSMENT SUBMITTED & APPROVED IF MORE THAN 7 DAYS	SECTION 3.4, C SECTION 3.6, A2	TO BE USED BY THE AA AND ALSA TO NOTIFY Community Options DELAY OF ASSESSMENT, REASSESSMENT OR STATUS REVIEW DETERMINATION. (REASSESSMENT) IF THERE ARE ANY PROBLEMS OR EXTENUATING CIRCUMSTANCES THAT WILL CAUSE A DELAY, THE ALSA MUST CONTACT Community Options IMMEDIATELY VIA TELEPHONE AND ALSO PROVIDE THE REASONS IN WRITING USING A DELAY NOTICE...THE ALLOWED DELAYS ARE AS FOLLOWS: THE CLIENT IS OUT OF THE FACILITY FOR LESS THAN TEN DAYS FOR PERSONAL REASONS, OR IS HOSPITALIZED.
20. SERVICE DELIVERY READY UPON PARTICIPANT'S PROGRAM ACCEPTANCE	STATE REGULATIONS, PG A13 – DPH ENFORCEMENT THE COMPLETE CLIENT SERVICE RECORD SHALL INCLUDEA CLIENT SERVICE PROGRAM...WITHIN 7 DAYS OF THE CLIENT'S ADMISSION TO THE AGENCY...	

21. ASSESSMENTS CONDUCTED IN NURSING HOMES OR HOSPITALS		
A. FOLLOW-UP VISIT CONDUCTED W/IN 5 DAYS OF DISCHARGE		
22. UNIFORM CLIENT CARE PLAN DESIGN	SECTION 3.4, C SECTION 3.6, A1 SECTION 9.1, B3 SECTION 9.1, B5	TO BE USED BY THE AA AND ALSA TO INDICATE THE TYPE OF SERVICES, FREQUENCY AND COST OF CARE FOR THE CLIENT. FOR THE DSS/CHCPE NON-ACTIVE CLIENTS/RESIDENTS DETERMINED ELIGIBLE AND WHO HAVE ACCEPTED ASSISTED LIVING SERVICES, THE ALSA MUST SUBMIT W/IN 7 WORKING DAYS TO Community Options THE FOLLOWING FORMS: A PROPOSED POC (W1510) IF AT ANY TIME THERE ARE ANY CHANGES TO THE POC, COST OF CARE, OR CLIENT APPLIED INCOME CONTRIBUTION, THE ALSA MUST HAVE AN UPDATED ... POC....IN THE CLIENT'S RECORD (REASSESSMENT) FOR DSS/CHCPE CLIENTS, THE ALSA WILL COMPLETETHE POC...THE ALSA WILL RETAIN THE ORIGINAL FORMS IN THEIR FILES.
23. POC IDENTIFIES ALL FORMAL CARE PROVIDERS	STATE REGULATIONS PG A14, – DPH ENFORCEMENT	
24. POC IDENTIFIES ALL INFORMAL SUPPORTS	STATE REGULATIONS, PG A14, – DPH ENFORCEMENT	
25. REVIEW OF BACK-UP PLAN NECESSITY DOCUMENTED		
A. BACK-UP PLAN DOCUMENTED		
26. CLIENT'S OR CLIENT REPRESENTATIVE'S SIGNATURE ON POC	SECTION 9.1,B5	THE ALSA SHALL SUBMIT COPIES OF THE UNIFORM POC SIGNED BY THE CLIENT/CLIENT REPRESENTATIVE,....TO THE APPROPRIATE Community Options. THE ALSA SHALL RETAIN THE ORIGINAL FORMS IN THEIR FILES.
27. CARE MANAGER'S SIGNATURE ON POC		
28. POC REVIEW / 30 DAY CONTACT MONITORING DOCUMENTED		
29. SIX MONTH CONTACT VISIT DOCUMENTED	STATE REGULATIONS , PG A13– DPH ENFORCEMENT (REVIEW OF CLIENT SERVICE PROGRAM EVERY 120 DAYS)	

30. POC MEETS CLIENT'S CURRENT NEDXC	STATE REGULATIONS, PG A13, – DPH ENFORCEMENT
31. CLIENT / FAMILY SATISFACTION W/ SERVICES DOCUMENTED MTHLY	STATE REGULATIONS , PG A15– DPH ENFORCEMENT REFERS TO AN ANNUAL REVIEW OF POLICIES ON EVALUATION OF CLIENT SATISFACTION.
32. IDENTIFICATION OF POTENTIAL PROBLEMS DOCUMENTED	STATE REGULATIONS, PG 14A, – DPH ENFORCEMENT
A. IMPLEMENTATION OF CORRECTIVE ACTION DOCUMENTED	STATE REGULATIONS, PG 14A, – DPH ENFORCEMENT

Appendix

Contact Information

Department of Social Services
Community Options
55 Farmington Ave.
Hartford, CT 06105
860-424-4904

Waiver Application Center

Department of Social Services
20 Meadow Road
Windsor, CT 06095

Department of Social Services Benefit Center

855-626-6632

The Benefits Center is staffed with workers dedicated to answering questions, processing change requests and providing information about other resources.

'MyAccount' – DSS clients can activate an online benefit account for 24/7 information and access – www.connect.ct.gov. This account can be used for applications and benefit renewals (redeterminations).

W1-LTC Application for Long Term Services and Supports/Waiver application.

This is the initial application to be completed while eligibility is being determined.

Paste this link in the browser to view the form. It is helpful if applicants/representatives look at the application to see what financial documents will be required and begin acquiring them.

https://portal.ct.gov/-/media/DDS/providergateway/W-1LTC-Section_N.pdf?la=en

W1-ER Renewal of Eligibility *(formerly known as redeterminations)*

Clients who are active on the program will receive a yearly benefit renewal form. Paste this link in the browser to view this form.

<https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Common-Applications/w-1er.pdf>

Provider Enrollment Agreement

<https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=CHC%20Agreement%20with%20Addendum.pdf&URI=Forms/CHC%20Agreement%20with%20Addendum.pdf>

DXC Website

This website is a resource for providers. Provider bulletins regarding updates or changes in the program are posted under Information, Publications. The provider manual, information about provider enrollment, provider services including training, fee schedules and other information. The provider manual includes a claim resolution guide. The Provider Assistance Center is available to provide assistance with submitting claims, claim denials, questions about provider enrollment and other technical assistance.

<https://www.ctdssmap.com/CTPortal/Home/tabId/36/Default.aspx>