CERTIFICATION OF ENROLLMENT STATUS
HOME AND COMMUNITY BASED SERVICES (HCBS)
CF-ES 2515, 05/2017
Instructions for Medicaid LTC Program

Purpose:
This form is used to communicate with the Department of Children and Families (DCF) regarding home and community-based services (HCBS) waiver recipients. While the form is used by several Medicaid waiver providers, these instructions are specific to the Medicaid Managed Care Long-Term Care (LTC) Program waiver only. This form should be used by the entities designated below for the following situations:

<table>
<thead>
<tr>
<th>Event</th>
<th>Responsible Party</th>
<th>Completing Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Eligibility:</strong></td>
<td>Aging and Disability Resource Centers (ADRCs)</td>
<td>Check “Application” and complete Sections II., III. a) and b), IV., VI., and VII. e) (if appropriate)</td>
</tr>
<tr>
<td><strong>Initial LTC Plan enrollment:</strong></td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete Sections II., IV., VI., and IX.</td>
</tr>
<tr>
<td><strong>Change in LTC Plans:</strong></td>
<td>New Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete Sections II., IV., VI., and IX.</td>
</tr>
<tr>
<td><strong>Nursing Facility Transition:</strong></td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete sections II., III. d), IV.,VI., and VII.</td>
</tr>
<tr>
<td><strong>Recipient Deceased:</strong></td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete sections II., III. f), IV., VI.</td>
</tr>
<tr>
<td><strong>Recipient Move</strong></td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete sections II., III. d), IV.,VI., and VII.</td>
</tr>
<tr>
<td><strong>Disenrollment</strong></td>
<td>TBD – will not be the Medicaid LTC Plan or LTC plan case manager</td>
<td></td>
</tr>
</tbody>
</table>
## Instructions for Medicaid LTC Program

### Header Section:

| **Application** | Check this box when the information contained on the form is for an individual applying for Medicaid HCBS waiver eligibility; if the individual already has existing Medicaid (other than SSI coverage, i.e., MS aid category code), select the “change” box. |
| **Change** | Check this box when the information contained on the form is for an individual already receiving HCBS eligibility or already receiving another form of Medicaid eligibility (other than SSI) and needs to change to HCBS eligibility. |

### Section II.

| **Name of Applicant/Recipient** | Enter the full name of the individual for whom the request is being made, their social security number, and, if appropriate, their designated/authorized representative. |
| **Client Social Security Number** | |
| **Designated Representative** | |

### Section III.

(Check the appropriate box for either a), b), c), d), e) or f)

| **a) was enrolled in the Medicaid (HCBS) waiver on...** | Enter the date the applicant was initially authorized to be enrolled in the LTC Program waiver. **This information should be completed by the ADRC only.** |
| **b) Level of Care effective date:** | Check the appropriate Level of Care box (Skilled, Intermediate I, Intermediate II) and enter the Level of Care effective date. **This information should be completed by the ADRC only.** |
| **c) will not be enrolled in the Medicaid HCBS waiver** | If the individual filed an application with DCF to receive HCBS but will not be enrolled in the waiver, enter the reason why. For the LTC Program, this item should only be completed by the ADRC or CARES staff. |
| **d) has a change in living arrangement** | If there has been any change in the individual’s living arrangement, this box must be checked and the accompanying information in Section VII., must also be completed in its entirety. |
| **e) was disenrolled from the Medicaid waiver (HCBS) on:** | This section should never be completed by the LTC Plan/case manager. |
| **f) died on** | Enter the date of death for the individual. |

### Section IV.

| **Case Management Agency** | For the LTC Program, enter either the ADRC’s agency name or the LTC Plan’s name. This information will be included in the individual’s record in order to receive future eligibility notices. |
| **Waiver Program** | Enter SMMC LTC Program |
| **Mailing Address** | Enter either the corresponding ADRC full address or LTC Plan’s full address in order to receive copies of the eligibility notices. |
| **Telephone Number (include area code)** | Enter either the ADRC’s phone number or the LTC Plan’s phone number. |
Section VI.

Certified By:  
Case Manager’s Name (print)  
Case Manager’s Signature  
Date

The individual completing the form at the ADRC or the LTC Plan must print their name, sign, and date the form prior to submitting the document to DCF. This individual should be knowledgeable to answer any questions regarding the submitted form.

Section VII. LIVING ARRANGEMENT INFORMATION:

a) Previous address:  
Enter the full address for where the individual was living prior to the change being reported. This applies to Nursing Facility transitions as well as community moves.

b) New address:  
Enter the full address for where the individual is now residing.

c) Effective date of new address:  
Enter the actual date when the individual moved.

d) Note type of living arrangement  
Indicate whether or not the individual is now living in the community, has moved into an Assisted Living Facility (ALF), etc. If the individual has moved into a nursing facility and will need ICP Medicaid, STOP. Do not use this form. Submit the 2506A form to DCF.

e) For ALFs only: Usual and Customary Room and Board Rate documentation provided:  
Enter the customary room and board rate. This rate is needed in order to appropriately calculate the individual’s patient responsibility amount and complete the financial eligibility.

Section VIII. CASE MANAGER COORDINATION CHECKLIST:

Has a current DCF eligibility specialist been notified?  
No/Yes  
Date

This section should only be used to alert DCF that the 2515 is a resubmission from a prior request. If known that the current submission of the form is a resubmission for the same event, check yes. If not, check no.

Section IX. NEW CASE MANAGER INFORMATION:

Recipient transferred to another Medicaid waiver Case Manager on (date):  
Case Management Agency:  
Contact Person:  
Mailing Address:  
Telephone Number:

For the LTC Program, when an individual first becomes enrolled with a Medicaid managed care LTC Plan and if/when the individual changes LTC plans, the new LTC Plan should complete this section. Enter the new LTC Plan’s name, the name of the assigned contact who can answer any questions regarding the individual’s enrollment into the plan/waiver, the LTC Plan’s full mailing address, and telephone number where the contact person can be reached.