DPHHS-SLTC -055 (Rev. 1/2014)

## STATE OF MONTANA Department of Public Health and Human Services

## ENTRANCE/DISCHARGE INTO MEDICAID HOME AND COMMUNITY BASED SERVICES

APPLICA	NT:		
Name:			Gender
	(Last)	(First)	(MI)
		Social Security Number:	Phone:
	NG AGENCY:		Date to County:
		Agency	/:
Address:			Phone:
ENROLLMENT REQUEST:			
Notification to eligibility case manager. County Office of Public Assistance:			
This is to notify you that the above-named individual has been enrolled in a Medicaid Home and Community Based Services (HCBS) Waiver Program. Please ensure that this recipient is listed in CHIMES as a waiver recipient with the waiver type listed below when Medicaid eligibility has been established.			
ADMIT REQUEST:			
Effective Date when HCBS is scheduled to start:			
HCBS	S coverage dates must be entere	d into CHIMES on the Waiver web p	age.
<b>HCBS</b>	Waiver:		
□ A <sub>2</sub>	ged Waiver	□ DD0208 Develop	omentally Disabled (DD) Comprehensive Services Waiver
□ Pł	nysically Disabled Waiver	□ DD1037 DD Su	pports for Community Working and Living Waiver
☐ Severe Disabling Mental Illness Waiver			
□ D:	D0607 DD Children's Autism V	Vaiver □ Other:	
DISCHARGE REQUEST:			
Effective Date when HCBS is terminated:			
HCBS coverage dates must be entered into CHIMES on the Waiver web page.			
то ве со	MPLETED BY COUNTY O	FFICE:	CASE NUMBER:
Notification to referral originator:			
	dividual approved for Medicaid	effective	
	Waiver span has been entered into CHIMES, effective		
	Individual denied Medicaid on		
Incurment (spend down) amount			
□ C:	ash Option and/or medical expe	nse.	
□ U:	☐ Using Home and Community Based Services for Aged and Physically Disabled.		
☐ Other (explain)			
Comments:			
Eligibi	ility Case Manager:		Date: