State of Florida
Department of Children and Families

Rick Scott
Governor

David E. Wilkins
Secretary

DATE: June 17, 2013 **TRANSMITTAL NO.: I-13-06-0007**

TO: Economic Self-Sufficiency Operations Managers
Economic Self-Sufficiency Program Offices

FROM: Lawayne E. Salter, Chief, Program Policy **(Signature on File)**

SUBJECT: Revised Certification of Enrollment Status for HCBS, CF-ES 2515 Form

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This memorandum is to inform staff that the *Certification of Enrollment Status for Home and Community Based Services (HCBS),* CF-ES 2515 form has been revised.

The CF-ES 2515 was revised for use in the implementation of a new HCBS waiver, the Statewide Medicaid Managed Care Long Term Care (SMMC LTC) waiver, which will be implemented by DOEA/CARES in August 2013. The new waiver will merge the existing waivers (Long Term Care Diversion, Channeling, Aged/Disabled Adult and Assisted Living waivers) into the new program.

Use of Revised Form CF-ES 2515

When the SMMC LTC is implemented, Aging and Disability Resource Centers (ADRC) will complete the revised CF-ES 2515 for all individuals who choose enrollment in the SMMC LTC/HCBS waiver. The following changes were made to the form to obtain the required information:

- Section lll b), lines 1 and 2: ADRC staff will complete the appropriate level of care information in this section.
- Section III c): Allows the case manager to enter the reason why an individual will not be enrolled.

The ADRC will route the completed Form CF-ES 2515 to the ACCESS Program for use in the application or ex-parte processing for SMMC LTC/HCBS applications.

If there are any questions, Regional office staff may contact Carrie Sheffield at (850) 717-4138.

Attachment

cc: Director (Jeri Flora)
Customer Call Center (Pat Badland, Irene Hill, Georgina Santana, Liesta Sykes)
EBT (Debbie McLemore)
FLORIDA Help Desk (Anthony Gaston)
Information Technology (Barbara Roglieri, Joe Vastola)
Medicaid Eligibility System (Suzanne Poirier, Susan Thomas)
Office of Appeal Hearings (Betty Zachem)
Office of Communications (Alexis Lambert)
Office of the General Counsel (Herschel Minnis)
Office of Quality Management (Cindy Mickler, Tonyaleah Veltkamp, Annette Wiechers)
Operations Research & Communications (William Martinez, Lynn Rossow)
Program Policy (Dorthene Baker, Jena Grignon, Connie Mathers)
Public Benefits Integrity (Amanda Huston, Sheri M. Lynn, Fred Young)
AHCA (Kathy Austin, Melanie Brown-Woofter, Lisa Gill, Peggy Hall, Shevaun Harris, Beth Kidder)
DOEA (Paula James)
Florida Bar Elder Law Section (Emma Hemness, Twyla Sketchley)
Florida Legal Services (Cindy Huddleston)

CERTIFICATION OF ENROLLMENT STATUS
HOME AND COMMUNITY BASED SERVICES (HCBS)

I. Department of Children & Families
Economic Self-Sufficiency Services

II. RE:

____
Name of Applicant/Recipient

____
Client Social Security Number

____
Designated Representative

III. This certifies that the above named applicant/recipient:

a) ☐ was enrolled in the Medicaid waiver (HCBS) on ______________________________.

b) ☐ ***(For SMMC Long-Term Care waiver only)*** Level of Care effective date: ____________
(State Medicaid Managed Care)

Level of Care (check one): ☐ Skilled ☐ Intermediate I ☐ Intermediate II

c) ☐ will not be enrolled in the Medicaid waiver (HCBS): (Enter reason below)

d) ☐ has a change in living arrangement. **(Complete next page.)**

f) ☐ was disenrolled from the Medicaid waiver (HCBS) on ____________________________.

IV. Case Management Agency:____

Waiver Program: ____

Mailing Address:____

Telephone Number (include area code): ______________________________

V. **If the above named applicant/recipient is enrolled in waiver services, you must report any changes to DCF/Economic Self-Sufficiency Services staff immediately.**

VI. ☐ Certified By:

______________________________ ______________________________
Case Manager's Name (Print) Case Manager's Signature

____
Date

CHANGE IN HCBS RECIPIENT'S LIVING ARRANGEMENT
UPDATE INFORMATION

VII. LIVING ARRANGEMENT INFORMATION:

a) Current Address:____

b) New Address:____

c) Effective date of new address:__________________________

d) Note type of living arrangement (e.g., nursing home, hospital, living with relatives, etc.):

____

NOTE: Do not complete the following sections unless the above change in the HCBS recipient's address results in a change in DCF Circuit/county <u>or</u> in the Case Management Agency.

VIII.CASE MANAGER COORDINATION CHECKLIST:

a) Has the current DCF eligibility specialist been notified? ☐ NO ☐ YES (Date):__________

b) Has the new DCF (Circuit/county) eligibility specialist been contacted? ☐ NO ☐ YES
If yes, date:____________

IX. CHANGE IN CASE MANAGER INFORMATION:

a) ☐ Recipient transferred to another Medicaid waiver Case Manager on (date) ___________.

b) ☐ New form CF-AA 2515 has been completed by the new Case Manager and forwarded to the new DCF Economic Self-Sufficiency Specialist's address.

X. NEW CASE MANAGER INFORMATION:

Case Management Agency:______________________________________

Contact Person: ____

Mailing Address: ____

Telephone Number (include area code): ____________________________