4.00
APPENDIX 12
COMMUNICATION: REASON FOR CONTACT

Provider Choice/Change

Provider list mailed – After Intake

This letter is in regard to the Home and Community Based Services (HCBS) initial referral completed on (date). HCBS participants are required to select a provider agency as part of the initial assessment process.

Please refer to the enclosed provider list. It is recommended you speak with your preferred agency/agencies to confirm they are accepting new clients and have availability in your area. Once you have selected a provider, please have the provider information available at the time of your assessment.

Please note: the Customer Service Center is closed on all state and federal holidays.

Provider list mailed – Change of provider request

The Division of Senior and Disability Services (DSDS) has attached a Home and Community Based Services (HCBS) Provider List(s) per your request or due to a request made on your behalf.

If you are in need of a provider change, please select a provider, contact the provider and confirm that the provider can accept your care plan. Once you have confirmation that the selected provider will accept your care plan with a tentative start date, please contact HCBS Intake's Customer Service Center at 866-835-3505 (Monday-Friday, 8:30am-3:00pm) to make a provider change request. Please note: the Customer Service Center is closed on all state and federal holidays.

Provider choice - After initial assessment

This letter is in regard to the Home and Community Based Services (HCBS) assessment completed on (date). You have met the qualifications for HCBS, but I am awaiting your choice of provider to begin your services. Please refer to the provider list (received during the assessment) (enclosed) or (mailed to you on (date)). Contact our office by (date) at the number below with your choice of provider. If our office does not hear from you by this date, the referral will be closed without any services being authorized.

Change in provider - Provider no longer available to provide services

This letter is to inform you that (name of provider) will no longer be providing your Home and Community Based Services (HCBS) through the Department of Health and Senior Services (DHSS), effective (date). Therefore, you will need to select a new provider. I have enclosed a copy of a provider list for your convenience. Please contact our office by (date) at the number below with your choice of provider. A lapse in service or closure of your case may result if our office does not hear from you by this date.

Change in provider – Provider acquisitions

This letter is being sent to you by the Missouri Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) in regard to your Home and Community Based Services (HCBS). DSDS was informed that (name of previous provider) transferred ownership to (name of new provider). As a result, your care plan has been updated effective (date) to maintain your current services and supports.

You have the right to choose any HCBS provider for your care plan. If you would like to change HCBS providers, please select a new provider and confirm they can accept your care plan. Once selected, contact our Customer Service Center by calling **866-835-3505**, Monday through Friday, from 8:30 a.m. - 3:00 p.m. Please note: the Customer Service Center is closed on all state and federal holidays. You may also request changes to your care plan online by going to https://health.mo.gov/seniors/ and clicking on the Online Person Centered Care Planning (PCCP) Request icon. Please contact our Customer Service Center if you need to request a current list of approved HCBS providers for your area.

<u>Care Plan Change/Services or Tasks</u> Care plan change

This letter is in regard to (your request) or ((provider name) request) for a care plan change for your Home and Community Based Services (HCBS). An attempt to reach you by phone has been unsuccessful. Please contact our office by calling the number below to discuss this care plan change request no later than (date). If our office does not hear from you by this date, it will be assumed your current care plan is satisfactory and it will remain unchanged.

Care plan reduction/closure – Provider requested

This letter is to inform you that (name of provider) has requested a care plan change for your Home and Community Based Services. According to our records, a service is not being used at the amount currently authorized. An attempt to reach you by phone has been unsuccessful. Please contact our office by calling the number below to discuss this care plan change request no later than (date). If our office does not hear from you by this date, it will be assumed the service is no longer needed and an adverse action will be sent.

Care plan changes (subsequent to an EDL Investigation)

This letter is in regards to recommendations made by the Office of Special Investigations (OSI) for changes to occur with your care plan for your Home and Community Based Services (HCBS). An attempt to reach you by phone has been unsuccessful. Please contact our office by calling the number below to discuss your care plan no later than (date). If our office does not hear from you by this date, The Division of Senior and Disability Services (DSDS) will take appropriate action to determine your continued eligibility (i.e., restricting Consumer Directed Services (CDS), authorizing other HCBS, and/or issuing an adverse action).

Provider change - Participant requested

This letter is in regard to your request to change providers for your Home and Community Based Services. An attempt to reach you by phone has been unsuccessful. Please contact our office by calling the number below to discuss this care plan change request no later than (date). If our office does not hear from you by this date, it will be assumed this provider change is no longer necessary and your service provider will remain unchanged.

Attempt to Contact

Initial assessment

This letter is in regard to a Home and Community Based Services (HCBS) referral through the Department of Health and Senior Services (DHSS). A face- to- face assessment must be completed to determine your eligibility for services. An attempt to reach you by phone has been unsuccessful. Please contact our office no later than (date) at the number below to discuss your options. If our office does not hear from you by this date, the referral will be closed without any services being authorized.

Initial assessment – Missed appointment

This letter is in regard to your scheduled assessment for Home and Community Based Services (HCBS) through the Department of Health and Senior Services (DHSS). A face-to-face assessment was scheduled with you for (date). You were not present for your scheduled assessment. A face-to-face assessment must be completed to determine your eligibility for services. Please contact our office by (date) at the number below to discuss your options. If our office does not hear from you by this date, the referral will be closed without any services being authorized.

Reassessment

This letter is in regard to your current Home and Community Based Services (HCBS) with (provider name) through the Department of Health and Senior Services (DHSS). For services to continue, an assessment of your needs is required annually. (The Department of Health and Senior Services) or (provider name) has attempted to reach you by phone but have been unsuccessful.

It is important for you to contact our office at the number below no later than (date) to schedule your annual assessment. If our office does not hear from you by this date, your services and case will be closed. An adverse action has been sent with this participant contact form to inform you of your appeal rights.

Reassessment – Missed appointment

This letter is in regard to your scheduled assessment for Home and Community Based Services (HCBS) through the Department of Health and Senior Services (DHSS). An assessment was scheduled with you for (date). You were not present for your scheduled assessment. A face-to- face reassessment must be completed to determine your continued eligibility for services in your home. Please contact our office by (date) at the number below to discuss your options. If our office does not hear from you by this date, your services and case will be closed. An adverse action has been sent with this participant contact form to inform you of your appeal rights.

Participant Choice Statement

This letter is in regard to your Home and Community Based Services (HCBS) through the Department of Health and Senior Services (DHSS). A current Participant Choice Statement (PCS) is a requirement for your case file. Please complete the Participant Choice Statement you received and return it to the address listed below. Failure to complete and return this form could result in the closure of your HCBS.

HCBS Assessment Attestation

This letter is in regard to your Home and Community Based Services (HCBS) through the Department of Health and Senior Services (DHSS). A current HCBS Assessment Attestation form is a requirement for your case file. Please complete the HCBS Assessment Attestation form you received and return it to the address listed below. Failure to complete and return this form could result in the closure of your HCBS.

Home and Community Based Options Letter (4.00 Appendix 9)

This letter is in regard to your interest in resources in your community. Please find enclosed a list of community options that may assist you in locating additional resources.

Authorized Representative Contact Letter

This letter is in regard to the participant's Home and Community Based Services (HCBS) through the Department of Health and Senior Services. Enclosed you will find a copy of the participant's Person Centered Care Plan. Additional forms must be signed and current in the participant's case record to ensure accurate service planning and delivery. Failure to complete and return these documents could result in the closure of the participant's HCBS.

Please complete the following documents and return to the address listed below:

- DHSS Notice of Privacy Policies and a Privacy Policies Acknowledgement Form;
- Participant Choice Statement Form; and
- HCBS Assessment Attestation Form