

**HSRS LONG-TERM SUPPORT MODULE**  
**MODULE TYPE A**

**REGISTRATION - Screen L1 N/U/I/E (Module Key: )**

1 Worker ID		2a Last Name			2b First Name		2c Middle Name		2d Suffix		3 MA Number (10 digits) OR SSN (9 digits)	
4 Client ID		5 Birthdate (mm/dd/yyyy)		6 Sex <input type="checkbox"/> F <input type="checkbox"/> M		7a Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		7b Race (Circle up to 5) <input type="checkbox"/> A=Asian <input type="checkbox"/> B=Black or African American <input type="checkbox"/> W=White <input type="checkbox"/> I=American Indian or Alaska Native <input type="checkbox"/> P=Native Hawaiian or Pacific Islander			8 Client Characteristics	
9 Level of Care		10 Marital Status		11 Living Arrangement Prior Current People		12 Natural Support Source		13 Type of Movement / Prior Location (Check 1) (Optional for COP assessment, plan, applicant register) <input type="checkbox"/> N=Relocated from general nursing home <input type="checkbox"/> D=Diverted from entering any type of institution <input type="checkbox"/> F=Relocated from ICF / MR facility <input type="checkbox"/> B=Relocated from brain injury rehab unit				
14 Special Project Status		15 County of Fiscal Responsibility		16 Court Ordered Placement <input type="checkbox"/> Y=Yes <input type="checkbox"/> N=No		17 MA Waiver Financial Eligibility Type <input type="checkbox"/> A=Categorically eligible <input type="checkbox"/> B=Categorically financially eligible - special income limit <input type="checkbox"/> C=Medically needy <input type="checkbox"/> D=COP eligible <input type="checkbox"/> N=Non nursing home level of care			18 Indicator for Waiver Mandate (Optional for COP assessment, plan, applicant register) <input type="checkbox"/> A=MA Waiver eligible <input type="checkbox"/> B=Not MA Waiver eligible <input type="checkbox"/> C=MA Waiver eligible but exempt			

**SERVICES - Screen L2 U/I (Module Key: )**

19 Episode End Date		20 Closing Reason		CIP1A and CLTS-W Only			*Provider Number Required for SPCs: 102 Adult day care 202/01/02 Adult family home 506 CBRF 604 Supportive and service coordination (CIP1A, 1B, BIW, CLTS-W, COR) 711 Residential care apt. complex 896 ICF-MR/NH residents <b>All COR SPCs</b>							
				21 Slot Number		22 Start Date						23 End Date		
				STATE USE ONLY		STATE USE ONLY								

PGM No	24 SPC/Subprogram	25 Target Group	26 LTS Code	27 Funding Source	28 SPC Start Date	29 SPC End Date	30 Provider Number * Required for some SPCs	31 SPC Review Date mm yyyy

**OPTIONAL DATA - Screen 18** **NOTE:** Street address, city, state, zip code and county are required for CIP 1A, 1B, BIW and CLTS-W.

Street Address			City		State	Zip Code	County	Telephone ( )
Case Review Date		Diagnosis	Family ID		Local Data		<b>Shaded areas are optional.</b>	

