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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02404 (05/2023) | | | | | | | | | | | | **STATE OF WISCONSIN** | | | | | | | | | | | | |
| **Family care, Partnership, pace, AND IRIS**  **Change routing instructions** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section A—Member or Participant Information**  The information in this section should match the information in ForwardHealth. If there has been a change in contact information, check the box at the bottom of the section and supply documentation to Income Maintenance (IM). When income maintenance (IM) receives the form showing corrections they will update the information in CARES. If the individual receives Supplemental Security Income (SSI), the managed care organization (MCO), PACE organization (PO), or IRIS consultant agency (ICA) should prompt the individual to contact the Social Security Administration (SSA) to update the information.  **Section B—Changes that may Affect Medicaid Eligibility and/or Long-Term Care Enrollment**  This section is completed when any of the potential reasons for a change in eligibility or enrollment for a member or participant is discovered. IM determines whether the information affects eligibility or enrollment. IM must process the reported change (s) within 10 days of receipt. The managed care organization (MCO), PACE organization (PO), or IRIS consultant agency (ICA) should verify the results of the reported change in CARES and FHiC 14 days after submission. The result should be documented in the box marked ‘MCO, PO, or ICA AGENCY USE’. If the reported change results in a disenrollment for the member or participant, the MCO, PO, or ICA will route the entire form to the ADRC to perform disenrollment counseling.  **Section C—IMD Admission**  The MCO, PO, or ICA enters the facility information, date of admission to the facility, the date of discharge, if known, and marks the appropriate checkbox for the expected length of stay for an IMD admission. If the stay is expected to be more than 30 days, provide a physician’s statement that the person is likely to return to the home or apartment within six months.  Family Care members Partnership members and IRIS participants between the ages of 21 and 64 who enter an Institute for Mental Disease (IMD) must be disenrolled from the program unless any of the following apply:   1. The individual between the ages of 21 and 64 is enrolled in Partnership and the Partnership MCO has elected to cover the IMD stay as an in-lieu of or alternate service; or 2. The individual between the ages of 21 and 64 is enrolled in Family Care, Partnership or IRIS and he or she is being admitted to the IMD to receive Residential Substance Use Disorder treatment; or 3. The individual is age 21, enrolled in Family Care, Partnership, or IRIS, was a resident of the IMD immediately prior to turning age 21 and continues to be an IMD resident after turning age 21. This exception only applies until the person’s 22nd birthday   If exempted under 1., 2. or 3 above no change routing form will be completed.  Services can continue to be provided to a resident of an IMD if they are under age 21 or age 65 or over.  Unless exempted under 1., 2. or 3. above, allIMD admissions of Family Care members, Partnership members or IRIS participants between the ages of 21 and 64 that exceed one day **MUST** be disenrolled. For example, if an individual is admitted on Monday and discharged on Tuesday no form F-02404 or disenrollment is required. If the individual is admitted on Monday and discharged on Wednesday form F-02404 is required and the individual will be disenrolled.  **Section D—Incarceration**  The MCO, PO, or ICA enters the name of the correctional facility, date of admission to the facility, and the date of discharge, if known.  MCO members, PO members, or IRIS participants who enter a Correctional Facility must be disenrolled from the program because these are ineligible Medicaid settings.  **All** incarcerations that exceed one day **MUST** be disenrolled. For example, if an individual is incarcerated on Monday and released on Tuesday no form F-02404 or disenrollment is required. If the individual is incarcerated on Monday and released on Wednesday form F-02404 is required and the individual will be disenrolled.  **Section E—Nursing Home Admission**  The MCO, PO, or ICA enters the name of the nursing home, date of admission to the facility, and the date of discharge, if known.  **Section F - Change of Address**  It is not necessary to complete a disenrollment form for individuals who choose to remain enrolled with the same MCO, PO or ICA and voluntarily move between counties or if the individual moves to another county due to an MCO/PO placement.  If an MCO or PO member voluntarily moves to another county and remains with the same MCO, PO or ICA, the ADRC or Tribal ADRS will end the current enrollment in FHiC and enter a new enrollment with the appropriate MCO ID using the effective date provided, if applicable. The ADRC or Tribal ADRS may need to select “other” and enter the correct MCO ID if the county of residence has not been updated. Income Maintenance will be responsible for updating the address, county of responsibility and the transfer of Medicaid eligibility. The MCO, PO or ICA may refer the individual to the receiving ADRC or Tribal ADRS for options and enrollment counseling regarding other available programs if the member is interested.  **Section G—Form Completed By**  The MCO, PO, or ICA completes this section with their agency name and contact information. The form is faxed along with supporting verifications to the appropriate IM processing unit.  For members or participants receiving benefits through a Tribal IM agency, fax to the number listed for the respective tribal agency at <https://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm#Tribes>.  For members or participants residing in Milwaukee county, fax to the Milwaukee Document Processing Unit at 1‑888‑409‑1979.  For all other members or participants, fax to the Centralized Document Processing Unit at 1-855-293-1822.  **Section H—ADRC or Tribal ADRS Information**  The ADRC or Tribal ADRS must offer disenrollment counseling to MCO members, PO members, and IRIS participants who are disenrolling from the program, including a disenrollment due to the loss of Medicaid eligibility. If the individual is in an IMD, incarcerated, has passed away, or moved out of state, disenrollment counseling cannot be performed. Complete the information regarding the ADRC or Tribal ADRS and the date the form was received. Include a detailed note in the client-tracking database including whether the individual has been disenrolled or will have their disenrollment pending, if the individual wishes to remain enrolled, and the outcome of disenrollment counseling.  The ADRC or Tribal ADRS must retain the originally signed member or participant requested disenrollment form, or an electronically scanned copy of the signed form, for ten years in the event of a records request. | | | | | | | | | | | | | | | | | | | | | | | | |
| **STATE OF WISCONSIN**  **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02404 (05/2023) | | | | | | | | | | | **CIP** | | | | | | | | | | | | | |
| Pages 3, 4, and 5 are to be completed by the managed care organization (MCO), PACE organization (PO), or IRIS consultant agency (ICA), with a copy sent to the income maintenance (IM) agency and ADRC or Tribal ADRS. | | | | | | | | | | | | | | | | | | | | | | | | |
| **A. PERSONAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – First | | | | | | MI | | | | | | | | | Last | | | | | | | | | |
|  | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Street Address | | | | | | | | | | | | | | | City | | | | | | | | Zip Code | |
| County of Residence | | | | | | | | | | County of Responsibility | | | | | | | | | | | | | | |
| American Indian/Alaskan Native  Yes  No | | | | | | | | | | American Indian/Alaskan Native Affiliation | | | | | | | | | | | | | | |
| Phone Number | | | | | | | | | | Cell Number | | | | | | | | | | | | | | |
| Date of Birth | Member ID No. (as shown in ForwardHealth) | | | | | | | | | | | | | | | Member or Participant Target Group (FE, ID or DD, PD)  FE  ID or DD  PD | | | | | | | | |
| Name of Contact | | | | | | | | | | | | | | Phone Number | | | | | | | Cell Phone Number | | | |
| Guardian  Spouse  Conservator  POA  Other:  Is there a protective placement order:  Yes  No If yes, County: | | | | | | | | | | | | | | | | | | | | | | | | |
| Street Address | | | | | | | | | | | | | City | | | | | | | | | | | Zip Code |
| Long-Term Care (LTC) Program  Family Care  Partnership  PACE  IRIS | | | | Name of MCO, PO, or ICA | | | | | | | | | | | | | | | | | | | | |
| Change in contact information – documentation attached. | | | | | | | | | | | | | | | | | | | | | | | | |
| **B. TYPE OF CHANGE** | | | | | | | | | | | | | | | | | | | | | | | | |
| Indicate the type of change, provide details in the applicable sections below, and submit any available verification.  Life Event  Death – Date:  Change in marital status  Change of address—Complete Section F  Change in living arrangement (Nursing Home, IMD or incarceration)—Complete Section C, D or E  Financial Eligibility  Failure to pay cost share or PACE premium  Increase in assets  Increase or decrease in income  Increase or decrease in medical or remedial and/or MA card coverable expenses  Increase or decrease in shelter expenses  Change in health insurance (coverage, premiums, start and end dates, Medicare)  Failure to complete Medicaid recertification (route to ADRC or Tribal ADRS ONLY)  Functional Eligibility  Failure to complete annual long-term care functional screen  Increase or decrease in level of care on the long-term care functional screen  Member is appealing functional screen outcome with MCO/PO and has requested that services continue pending the outcome of the appeal  IM keep Medicaid benefit plan open  Member services were continued pending MCO/PO decision on appeal of functional screen outcome. The MCO/PO appeal decision did not change the functional screen outcome and the member did not request a fair hearing of that decision  IM close Medicaid benefit plan  PACE or Partnership ONLY:  Disenrollment from the MCO’s Dual Eligible SNP or PACE plan  Disenrollment from the PO’s Medicare Part D Plan (if the participant is eligible for Medicare D)  Refusal to select a primary care provider in the MCO or PO’s network | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional Information** | | | | | | | | | | | | | | | | | | | | | | | | |
| **C. IMD Admission** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Note:** Services are not covered for Family Care, Partnership and IRIS IMD residents between the ages of 21 and 64 years of age, except that (1) services may be provided to a 21-year-old Family Care, Partnership or IRIS resident of an IMD if the person was a resident immediately prior to turning 21 and continues to be a resident after turning 21; (2) services may be provided to a Partnership resident between the ages of 21 and 64 if the MCO has elected to cover the IMD stay as an in-lieu of or alternate service; and (3) services may be provided to a Family Care, Partnership or IRIS resident admitted to the IMD to receive Residential Substance Use Disorder treatment.Unless exempted under (1), (2) or (3) above, all IMD admissions of Family Care members, Partnership member or IRIS participants between the ages of 21 and 64 that exceed one day **MUST** be disenrolled. This form will not be completed if the IMD admission meets exemption 1., 2. or 3 above. | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of IMD | | | | | | | | | | | | | | | | | | Phone Number | | | | | | |
| Address of IMD | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Admission  IMD stay is expected to be:  Less than 30 days  30+ days (provide physician’s statement to IM)  Unknown  Date of Discharge | | | | | | | | | | | | | | | | | | | | | | | | |
| **D. Incarceration** | | | | | | | | | | | | | | | | | | | | | | | | |
| **All Incarcerations** that exceed one day **MUST** be disenrolled. | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Correctional Facility | | | | | | | | | | | | | | | | | | Phone Number | | | | | | |
| Address of Facility | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Incarceration/Date of Disenrollment | | | | | | | | | Date of Discharge | | | | | | | | | | | | | | | |
| **E. Nursing Home Admission** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Nursing Home | | | | | | | | | | | | | | | | | | | Phone Number | | | | | |
| Address of Nursing Home | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Admission  Date of Discharge | | | | | | | | | | | | | | | | | | | | | | | | |
| **F. CHANGE OF ADDRESS/MOVE** | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason:  Voluntary  The member has requested to move to a new living arrangement or to move to a new city or county  The guardian has requested to move to a new living arrangement or to move to a new city or county.  The MCO or PO has initiated a change that includes a new living arrangement or a move to a new city or county. This change may have been initiated as a result of a change in condition, loss of a caregiver or provider, to assure the least restrictive setting, to provide a more cost-effective option or other reason to best meet the member’s needs. | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Residence individual **was** living in:  Nursing Home  AFH  CBRF  Own home or apartment  RCAC  Hospital | | | | | | | | | Type of Residence individual **moved to**:  Nursing Home  AFH  CBRF  Own home or apartment  RCAC  Hospital | | | | | | | | | | | | | | | |
| Type of Move:  Continuing with current MCO, PO, or ICA  Effective date of change, if applicable:  Move out of state  Effective date of disenrollment: | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Move | | | County or State Moving From | | | | | | | | | | | | | | County or State Moving To | | | | | | | |
| Facility Name (if applicable) | | | | | | | | | | | | | | | | | | | | | | | | |
| New Address (Street, City, State, Zip Code) | | | | | | | | | | | | | | | | | | | | | | Phone Number | | |
| **G. FORM COMPLETED BY** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – MCO, PO, or ICA Worker | | | | | | | | Date Completed and Faxed to IM and ADRC or Tribal ADRS | | | | | | | | | | | | | | | | |
| Email Address | | | | | | | Phone Number | | | | | | | | | | | Fax Number | | | | | | |
| **MCO, PO, or ICA AGENCY USE:** Check the appropriate boxes, complete details, and route entire form to ADRC or Tribal ADRS.  No Change in Eligibility or Enrollment  Change in Cost Share or Patient Liability Amount:  New Amount:      Effective Date:  Loss of Functional Eligibility  Loss of Financial Eligibility  MCO/PO No Longer Providing Services Effective Date:  Comments and or Additional Information: | | | | | | | | | | | | | | | | | | | | | | | | |
| **This section to be completed by the ADRC or Tribal ADRS only.** | | | | | | | | | | | | | | | | | | | | | | | | |
| **H. ADRC or Tribal ADRS INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| ADRC or Tribal ADRS of | | | | | County/Tribe | | | | | | | | | | | | | | | Date Form Received | | | | |
| Name – ADRC or Tribal ADRS Worker | | | | | | | | | | | | | | | | | | | | Date Completed | | | | |
| Phone Number | | Email Address | | | | | | | | | | | | | | | | | | | | | | |
| ADRC enters the following information in the notes of the Client Tracking Database:   * Customers status at the time the form is received * The outcome of disenrollment counseling * Customer preferences regarding continued enrollment * ADRC or Tribal ADRS ability to assist the customer to remain enrolled or re-enroll | | | | | | | | | | | | | | | | | | | | | | | | |
| **If the member has voluntarily moved to a new county and is remaining enrolled with the same MCO, the ADRC or Tribal ADRS staff has confirmed and updated MCO ID and County of Responsibility in FHiC if applicable.**  **If the MCO/PO is no longer providing services, the ADRC will enter or change the end reason code to the following to avoid system re-enrollment:**   * + 72 No reason provided | | | | | | | | | | | | | | | | | | | | | | | | |