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A. NEW APPLICANTS

Step A1: SEARCH FOR COMSUMER

- 1) Click Consumer
- 2) Click Search = enter SS# or name
- 3) Click "Find"
- 4) If found, consumer will show up in box below. Double click name to open consumer.

Step A2: ADDING A CONSUMER

1) Click "New" – This will automatically put you in the "Details" section with the "General" page open.

2) On the "General Page" Enter:

First Name

Middle Initial (if there is one on the application)

Last Name

Gender

Date of Birth

SS# (Verify SS# from the DCF Medicaid Notice when received)

Info Authorized = Yes

Phone Number

Residential Address = Physical address of the individual's residence. **NOTE:** For permanent NH and ERC enrollments = enter the physical address of the NH or ERC

Mailing Address = Enter if different than residential address. This is the place mail is sent to the consumer.

Municipality = Choose municipality of the client's residential address.

NOTE: If the person is already in SAMS, review above information and update/correct as necessary. Do **NOT** change the **Date Registered**.

STEP A3: ADDING A CASE MANAGER

- 1) Under Details, Click on "Care Managers" tab on the left
- 2) Click "Add Care Manager" on the tool bar
- 3) Type in or choose the case manager's name from the drop-down list.

If an individual case manager hasn't been identified yet (moderate needs, wait list) enter the chosen Case Management Agency. When you know who the individual case manager is update this field. NOTE: If case manager is not on the list, enter Agency Name and contact LTCCC supervisor.

- 4) **Primary** = yes
- 5) **Enter Start Date** = CFC application date
- 6) **End Date** = none

NOTE: This care manager must also be listed when you go to enter a care plan.

STEP A4: ADDING A LOCATION - For permanent NH and ERC enrollments only.

- 1) Under Details, Click on "Location" tab on the left
- 2) Click "Add a Location" on the tool bar
- 3) **Type** = "Address prior to NH/RCH/ALR Admission"
- 4) From CFC application, enter county, town and state of the individual prior to NH, RCH, ALR admission
- 5) Click "OK"

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STEP A5: SETTING AT APPLICATION - Where someone was when they applied.

- 1) Under Details, click “User Fields” tab on the left
 - 2) Click on “Add User Field”
 - 3) User Field – choose “Setting at App” from Drop Down list
- The Prompt will give you the choices (R=Home, N=NF, E=ERC, H=Hosp, C=Corr)
Enter the appropriate LETTER from the prompt into the Value field
This is where the person was when they applied and is on the CFC application form.
Click “OK”

B. ENTERING CARE ENROLLMENTS

STEP B1: BEFORE CLINICAL REVIEW IS DETERMINED

- 1) Under Details, click “Care Enrollments” tab on the left
- 2) Open “System Generated Default” enrollment
- 3) Change **Level of Care** = LTC Waiver (CFC undetermined)
- 4) Change **Service Program** = LTC Waiver CFC undetermined setting
- 5) **Care Program** = Automatically Populates
- 6) Enter **Application Date** = Date application is signed or date Medicaid is needed for NH setting if prior to the application date. Start Date cannot be prior to Application Date. **NOTE:** If application is returned for missing information/signature, use the latest received date.
- 7) Enter **Received Date** = Date application was date stamped received in the office.
- 8) Enter **Status** = “Received” OR “On Hold”
- 9) Enter **Reason** = “pending LOC determination” OR “LOC on hold”
- 10) **Start Date** = none
- 11) **Status Date** = date you received the application

NOTE: “On Hold” status is only used when the clinical eligibility process is put on hold due to an undetermined setting, discharge plan or is in an acute stage in hospital and isn’t ready for an assessment. Create a “Journal” entry to describe the “On hold” circumstances. When the “On Hold” status ends, it is important to update the enrollment status to the appropriate Status and Reason (e.g. “Received”, “pending LOC determination”).

STEP B2: AFTER CLINICAL DETERMINATION IS COMPLETE

- 1) Under Details, click “Care Enrollments” tab on the left
- 2) Double click the current enrollment “LTC Waiver CFC Undetermined”
- 3) Change **Level of Care** = appropriate level (e.g. Highest, High, etc).
- 4) Change **Service Program** = appropriate service setting
- 5) Change **Status** = “Pending Medicaid Eligibility” OR “On HOLD”
- 6) Change **Reason** to = “LOC approval complete” OR “Setting on hold”
- 7) Change **Status Date** = date of clinical determination
- 8) **Start Date** = No start date

Level of Care = Highest, Highest Special Circumstance, High, High Special Circumstance, Moderate
Service Program = NH, NH Short Term, NH NAPA, ERC, Home, Flexible Choices, PACE

NOTE: “On Hold” status is only used when the financial eligibility process is put on hold due to an undetermined setting or discharge plan. Create a “Journal” entry to describe the “On hold” circumstances. When the “On Hold” status ends, it is important to update the enrollment status to the appropriate Status and Reason (e.g. “Pending Medicaid Eligibility”, “LOC approval complete”).

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STEP B3: PENDING SERVICE PLAN STATUS – AFTER financial determination but BEFORE HB/ERC Service Plan received. (Service plans should be created within 14 days of clinical cert, but the service plan is not always in before Medicaid determination.)

- 1) Under Details, click “Care Enrollments” tab on the left
- 2) Edit the current care enrollment
- 3) Change **Status** = Pending Service Plan
- 4) Change **Reason** = Pending Service Plan
- 5) **Start Date** = No start date
- 6) Change **Status Date** = Date you received the DCF Notice of Decision

STEP B4: ACTIVE CARE ENROLLMENT – AFTER financial determination and AFTER HB/ERC Service Plan approved.

- 1) Under Details, click “Care Enrollments” tab on the left
- 2) Edit the current enrollment
- 3) Change **Status** = Active
- 4) Change **Reason** = Eligible
- 5) **Start Date** = enter date eligible per DCF Notice of Decision
- 6) Change **Status Date** = Date the last eligibility criteria was met = Date you signed HB/ERC Service Plan or date you received the DCF Notice of Decision for nursing home.

C. ENTERING A CARE PLAN

STEP C1: CREATING A CARE PLAN - After initial approval.

- 1) Click on “Care Management” to the far left under “Contents”
- 2) Click “New Care Plan”
- 3) For HB & ERC, enter **Primary Care Manager** = name of case manager on Service Plan
- 4) For HB & ERC, enter **Provider Role** = Care Manager
- 5) For Flexible Choices, enter **Primary Care Manager** = name of Consultant on Allowance form
- 6) For Flexible Choices, enter **Provider Role** = FC Consultant
- 7) Enter **Service Program** = choose applicable CFC enrollment from drop down list
- 8) Enter **Start Date** = date service plan/allowance starts (HB & ERC) or Medicaid start date for NH
- 9) Enter **End Date** = date service plan/allowance ends (HB & ERC) or 20 years from start date for NH
- 10) Enter **Status** = active
- 11) Enter **Reason** = initial
- 12) Click on “OK”

NOTE: Ignore the Care Plan Status date. The Care Plan start date may be later, but not earlier, than the care enrollment start date.

STEP C2: ENTERING SERVICES

- 1) With the Care Plan open, click on “**Service Plan**”
- 2) Click on “**Add Service**” on tool bar

On Left Side of Split Screen Enter:

- 3) **Service Category** will auto populate after **Service** entered. Some times you may need to re-enter after
- 4) Enter **Service** = Choose appropriate service from drop down list.
- 5) Enter the **agency name and provider type** for all services. See note on provider choices below.
- 6) **Verify** rate of each service. If not correct, manually enter the correct rate per reference rate chart.
- 7) Enter **special instructions as needed** (e.g. items approved for assistive devices)

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NOTE: Order of data fields may be changed through the formatting option.

On Right Side “Service Plan Schedule”

8) Click **Add**

9) Enter **Units Allocated** =

- **Case Management** units = enter # hours/month = annual hours from Service Plan divided by 12 (Max = 48 hrs/year = **4 units**)
- **ERC & NH & DAIL Personal Care Daily Rate** units = enter 30.3 (days/month)
- **HB Personal Care units** = enter # of bi-weekly hours from Service Plan
- **HB Adult Day units** = enter # of bi-weekly hours from Service Plan
- **HB Companion/Respite** units = enter # hours/month = annual hours from Service Plan divided by 12. (Max = 720 hrs/year = 60 units)
- **PERS, Assistive Devices and Flexible Choices** units= enter 1

10) Enter **Allocation Type** =

- **Case Mgt, ERC, NH, DAIL Personal care, FC, Respite/Companion** = Monthly
- **Personal Care and Adult day** = Weekly
- **Assistive Dev/Home Mod and PERS Installation** = Duration Specified

11) Enter **Frequency** =

Case Mgt, ERC, NH, DAIL Personal care, FC, Respite/Companion = 1
Personal Care and Adult day = 2

12) Click **Apply and Close**

NOTE: The unit prices must be entered after the provider is entered. Unit Price will automatically populate except for:

- **Personal Care Daily Rate** = approved daily budget
- **Flexible choices** = approved monthly allowance
- **Assistive Devices** = total dollar amount approved

NOTE on Services:

- **HB** = Enter all services on Service Plan
- **NH setting** = Enter nursing home service only
- **ERC setting** = Enter case management and tier
- **PACE** = Enter PACE service only
- **Flexible Choices** = Enter flexible choices monthly allocation only
- **HB Personal Care Daily Rate** = Enter one personal care daily rate only
- **ISO Fee** = 1 unit

NOTE on Provider choices:

Case Management = AAA Agency or Home Health Agency **ONLY**

D. TRANSFER OF SETTING WITHIN CFC – Permanent Move

Each time a CFC participant makes a setting change that is expected to be permanent you must follow these steps.

1) End OLD Care Plan

- a) Open Consumer
- b) Click on “Care Management” on left
- c) Open current care plan and click “Modify Plan” upper right corner

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- d) Change the **End Date** = same date the person is terminating that setting
 - e) Change **Status** = Inactive
 - f) Change **Reason** = initial ended or change ended or reassessment ended (choose one)
 - g) Click “OK” and close care plan
- 2) End OLD Care Enrollment
- a) Open “Details” and go to “Care Enrollments”
 - b) Open the Enrollment of the setting that needs to be terminated (double click or “Edit Care Enrollment”)
 - c) Enter **Termination Date** = the last day of the old setting
 - d) Change **Status** = Terminated
 - e) Change **Reason** = Applicable reason to match change in setting = HB to ERC, HB to NH, HB to FC, ERC to HB, etc. (see full list of reasons on page 11)
 - f) Enter **Status Date** = Date you received the Change Form or Service Plan
 - f) Enter **End Date** = Same as Terminated Date
 - g) Click “OK”
- 3) Add a NEW Care Enrollment for the New Setting.
- a) Under Details, click “Care Enrollments” tab on the left
 - b) Click “Add Care Enrollment”
 - c) Enter **Level of Care** = Applicable Level of Care (e.g. highest, high, etc)
 - d) Enter **Service Program** = Applicable CFC setting
 - e) **Care Program** = automatically populates
 - f) Enter **Application Date** = Date they transferred to new setting
 - g) Enter **Received Date** = Date you received Change Form
 - h) Enter **Status** = Active
 - i) Enter **Reason** = Eligible
 - j) **Start Date** = Date of New Setting
 - k) **Status Date** = Date you received the Change Form or Service Plan
- 4) Add a NEW care plan and services, see “**C. Entering a Care Plan**”.
- 5) Go to “Details” and verify the correct address. Change if not correct. Add a **Location** for permanent change to ERC or NH, see “**Step A4: Adding a Location**” on page 1.

E. TEMPORARY NURSING HOME STAY

For a temporary admission to a nursing home, you must add a new enrollment and care plan. However, do NOT close the existing enrollment or care plan.

- 1) Add a NEW Care Enrollment for the temporary setting.
 - a) Under Details, click “Care Enrollments” tab on the left
 - b) Click “Add Care Enrollment”
 - c) Enter **Level of Care** = LTC Waiver Nursing Home short-term OR LTC Waiver Nursing Home short term (VHAP-Medicaid)
 - d) Enter **Service Program** = Applicable CFC setting
 - e) **Care Program** = automatically populates
 - f) Enter **Application Date** = Date they transferred to new setting
 - g) Enter **Received Date** = Date you received Change Form
 - h) Enter **Status** = Active
 - i) Enter **Reason** = Eligible
 - j) **Start Date** = Date of New Setting
 - k) **Status Date** = Date you received the Change Form

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- 4) Add a NEW care plan and services, see “**C. Entering a Care Plan**”.
- 5) When Discharge Notice is received from nursing home, update status and end date of both the care plan and short-term enrollment.

NOTE: For temporary stays, the end date for nursing home care plan must be 6 months from the start date.

If NH stay becomes permanent:

- 1) Put end date on both HB or ERC and NH Short Term care plans and make them “Inactive”. The status date should be the date you were informed that it is a permanent placement.
 - 2) The end date should be the date that enrollment ended.
 - 3) Terminate the HB or ERC and NH Short Term Care Enrollments.
- Enter New Care Enrollment and Care Plan for LTC Waiver Nursing Home (Choices for Care).

F. HB & ERC SERVICE PLAN CHANGES & REASSESSMENTS

Follow these steps if the change or reassessment is in the same setting and same level of care. If NEW setting or level see “D. Transfer of Setting” or “G. Level of Care Change”.

- 1) Open Consumer
- 2) Go to “Details” and verify the correct address. Change if not correct.
- 3) Click on “Care Management” on left
- 4) Highlight most current Choices for Care Service Plan
- 5) Click on “Copy Care Plan” if in same setting and same level of care.
- 6) Under **Source Care Plan**
 - a) Enter End Date (day before the new Service Plan starts)
 - b) Change **Status** from **Active** to **Inactive**
 - c) Change **Reason** to Initial, Change, Reassessment **Ended**
- 6) Under **New Care Plan**
 - a) Status (active)
 - b) Reason (Initial, Change, Reassessment)
 - c) Enter Start Date
 - d) Enter End Date
 - e) Click OK

NOTE: SAMS will make a copy of the care plan and open to the Care Plan Summary page
Click on Service Plan (either on the left or lower left part of summary).

- 7) To Delete a service
 - Highlight service you want to delete
 - Click on Delete Service
- 8) To Modify a service (i.e. adding another assistive device \$ amount, volume of personal care)
 - Double click on the service that needs modifying (this will open the service)
 - Modify volume, provider etc.
 - You can either click Save then Click the “X” in the right hand corner or click the “X” and it will ask if you want to save changes, click “yes”.
- 9) To Add a service
 - Click Add Service
 - Once all services are added and correct click “Save and Close”.

G. LEVEL OF CARE CHANGE

If at anytime a CFC participants' level of care (LOC) changes from Highest to High or High to Highest you need to change care enrollments and care plans.

- 1) End OLD Care Plan
 - a) Open Consumer
 - b) Click on "Care Management" on left
 - c) Open current care plan and click "Modify Plan" upper right corner
 - d) Change the **End Date** = same date the person is terminating that level of care
 - e) Change **Status** = Inactive
 - f) Change **Reason** = initial ended or change ended or reassessment ended (choose one)
 - g) Click "OK" and close care plan
- 2) End OLD Care Enrollment
 - a) Open "Details" and go to "Care Enrollments"
 - b) Open the Enrollment of the setting that needs to be terminated (double click or "Edit Care Enrollment")
 - c) Enter **Termination Date** = the last day of the old level of care
 - d) Change **Status** = Terminated
 - e) Change **Reason** = Changed Level
 - f) Enter **Status Date** = Date you determined the new level of care
 - f) Enter **End Date** = Same as Terminated Date
 - g) Click "OK"
- 3) Add a NEW Care Enrollment for the New Setting.
 - a) Under Details, click "Care Enrollments" tab on the left
 - b) Click "Add Care Enrollment"
 - c) Enter **Level of Care** = Applicable Level of Care (e.g. highest, high, etc)
 - d) Enter **Service Program** = Applicable CFC setting
 - e) **Care Program** = automatically populates
 - f) Enter **Application Date** = Date of new level of care
 - g) Enter **Received Date** = Date you received Change Form
 - h) Enter **Status** = Active
 - i) Enter **Reason** = Eligible
 - j) Enter **Start Date** = Date of new level of care
 - k) Enter **Status Date** = Date you determined the new level of care
- 4) Add a NEW care plan and services, see "**C. Entering a Care Plan**".

H. TERMINATIONS

A termination is when an individual's CFC enrollment was active for any period of time, and then the individual terminated from CFC for an identified reason.

- 1) Open Consumer
- 2) Click on **Care Management**
 - a) Open current Care Plan
 - b) Click "modify plan" on upper right corner
 - c) Change **End date** = same date as termination
 - d) Change **Status** = Inactive
 - e) Change **Reason** = (initial, change, reassessment) ended

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- f) Save and close care plan
- 3) Click on **Care Enrollment**
- 4) Enter **Termination Date** = effective date on termination form or date previous setting ended (for change in setting)
- 5) Change **Status** = Terminated
- 6) Enter **Reason** = appropriate reason from list (see full list of reasons on page 11)
- 7) Enter **Status Date** = effective date of notification (date Change Form received or information reported in another acceptable way)
- 8) Enter **End Date** = same as termination date
- 9) Save and Close

For Terminations Due to Death, also update the general status.

- 1) Click on General
- 2) Highlight Status
- 3) Change **Active** from Yes to No
- 4) Enter **Reason** to Deceased
- 5) **Status Date** = date the person died
- 6) Save and Close

I. DENIALS

A denial is when someone applies for CFC and is found ineligible by DAIL or DCF. The enrollment was never made active and the individual did not receive services paid for by CFC. If participant has been enrolled in CFC and is subsequently found ineligible, terminate them using the status Terminated NOT Denied.

- 1) Open Consumer
- 2) Click on **Care Enrollment**
- 3) Change **Status** = Denied
- 4) Enter **Reason** = appropriate reason from list (see full list of reasons on page 11)
- 5) Enter **Status Date** = effective date on clinical denial letter or date DCF denial notice received
- 6) Save and Close

NOTE: No start or end dates because services were not used.

J. APPLICATION CLOSED

Application Closed is used only when a person applied for CFC then the application was closed before becoming active, without being denied by DAIL or DCF.

- 1) Open Consumer
- 2) Click on Care Enrollment
- 3) Change **Status** = Application Closed
- 4) Enter **Reason** = appropriate reason from list (see full list of reasons on page 11)
- 5) Enter **Status Date** = effective date of notification (date Change Form received, or date of CFC closure notice (no Medicaid application received), or date information reported in another acceptable way)
- 6) Save and Close

NOTE: No start or end dates because services were not used.

K. WAIT LIST

- 1) Open Consumer
- 2) Click on Care Enrollment
- 3) Change **Level of Care** = LTC High
- 4) Enter **Service Program** = Service setting they applied for in CFC
- 5) Change **Status** = Waiting
- 5) Enter **Reason** = Wait list CFC
- 6) **Start Date** = none
- 7) Click **Save**

Add an Activity/Referral

- 1) Click on **Activities and Referrals** (main menu on far left)
- 2) Click on **Add Activity/Referral** (task bar at top)
- 3) Type in **Subject** = "CFC wait list"
- 4) Enter **Action** = HB waiting, or NH waiting, or ERC waiting, PACE Waiting, Flexible Choices Waiting
- 5) Enter **Status** = waiting
- 6) Enter **Status Date** = date of waiting list notice
- 7) Enter **Start Date** = date of clinical determination

Add User Field

- 1) Click on Details (main menu on far left)
- 2) Click on **User Field**
- 3) Click on **Add User Field**
- 4) **User Field** = CFC Wait Score
- 5) **Prompt** = CFC Wait Score
- 6) Value = Enter Score
- 6) Click **OK**

L. REMOVAL FROM WAIT LIST

- 1) Open Consumer
- 2) Click on **Activities and Referrals** (main menu on far left)
 - Open the CFC Wait List **Activity/Referral** (double click or edit activity/referral)
 - Status** = change to Completed
 - Reason** = died, withdrew, went on program
 - Date Completed** = enter the date off wait list
- 3) If they went on CFC
 - Click on Care Enrollment
 - Open CFC waiting
 - Change Level of Care
 - Enter **Status** = Pending Medicaid Eligibility, or Pending Service Plan, or On Hold
 - Start Date** = none
 - Status Date** = date they came off wait list

M. CORRECTING/UPDATING CASE MANAGER

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If an incorrect case manager name is showing up on reports or in SAMS you need to update case manager information.

- 1) Under **Details** click on Care Manager, Add Care Manager and enter the correct case manager with the date they started case managing the client.
- 2) Go to Care Management, open the care plan with the incorrect Case Manager,
- 3) On Right hand side click on “Care Managers”
- 4) Click on Add Care Manager
- 5) **Care Provider** = enter case manager’s name
- 6) **Primary** = yes
- 7) **Provider Role** = Care Manager

NOTE: If not on the list, contact LTCCC supervisor.

Enrollment Status and Reasons Table

Enrollment Status & Definition	Reasons
Active: Clinical and financial eligibility complete.	<ul style="list-style-type: none"> • Eligible • Special circumstances
Application Closed: Eligibility not complete and services not provided. Enrollment was never made “Active”.	<ul style="list-style-type: none"> • Deceased before decision • No Medicaid application • Voluntary withdrawal before decision
Denied: Clinically or financially <u>ineligible</u> and services not provided. Enrollment was never made “Active”.	<ul style="list-style-type: none"> • Denied - moved out of state • Denied - other • Denied - unable to contact • Ineligible for LOC • Ineligible for Medicaid • Needs met by other program • Variance denied (ERC)
On Hold: Clinical eligibility process is on hold due to undetermined setting, discharge plan or is in an acute stage in hospital and isn’t ready for an assessment.	<ul style="list-style-type: none"> • LOC on hold • Setting on hold
Pending Medicaid Eligibility: Clinically eligible, waiting for financial determination.	<ul style="list-style-type: none"> • LOC approval complete
Pending Service Plan: Clinically and financially eligible, waiting for Service Plan only.	<ul style="list-style-type: none"> • Pending service plan
Received: CFC application has been received, clinical and financial eligibility NOT yet complete.	<ul style="list-style-type: none"> • Pending LOC determination
Terminated: Enrollment was previously “Active”, and then enrollment was closed.	<ul style="list-style-type: none"> • Changed level • ERC to FC • ERC to HB • ERC to NH • ERC to PACE • Family will provide all care • FC to ERC • FC to HB • FC to NH • FC to PACE • HB to ERC • HB to FC • HB to NH • HB to PACE • Hospitalized • Moved out of state (any program) • NH to ERC

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	<ul style="list-style-type: none"> • NH to FC • NH to home • NH to PACE • PACE to ERC • PACE to FC • PACE to HB • PACE to NH • Terminated - deceased • Terminated - ineligible for LOC • Terminated - ineligible for Medicaid • Terminated - needs met by other program • Terminated – non use of hours • Terminated - other • Terminated - voluntary withdrawal, estate recovery • Terminated - voluntary withdrawal, other • Variance terminated (ERC)
<p>Waiting: On “High Needs” wait list.</p>	<ul style="list-style-type: none"> • Wait list CFC

Trouble Shooting

- 1) Data Entry –
 - a. Follow SAMS instructions
 - b. If issue is not identified in SAMS instructions, or the instructions do not work, contact Tracey Harrington or Dick Lavery. If emailing, send an email to both.
 - c. If Tracey and/or Dick can not resolve the problem, they will stop and bring the issue to the SAMS Management and Resolution Team (SMaRT).
 - d. SMaRT will evaluate the problem and determine next steps for fixing the problem.
 - e. SMaRT will determine what changes are necessary to the SAMS instructions and coordinate the implementation of the new instructions.
 - f. After instructions are updated, SMaRT will communicate changes to LTCCC group.

- 2) New Case Managers or CFC Providers –
 - a. LTCCC will contact the Medicaid Waiver Supervisor when a case manager or provider is not found in SAMS.
 - b. The Medicaid Waiver Supervisor will determine the appropriate DAIL staff to verify case manager or provider information.
 - c. The Medicaid Waiver Supervisor will send verified information to Tracey Harrington and/or Dick Lavery for input into SAMS.

- 3) Questions Regarding Reports –
 - a. LTCCC will contact Tracey Harrington with questions regarding SAMS reports.
 - b. If Tracey can not resolve the report issue, she will bring to SMaRT for review.
 - c. SMaRT will determine if a new or updated report is necessary for the individual LTCCC or group.