Instructions for completing LTHHCP LDSS Quarterly Report

County: Enter location name of LDSS (i.e. Albany)
Date: Enter date report submitted to DOH (report due within 15 days after quarter ends)
Submitted by: Enter name of LDSS staff member completing report
Phone #: Enter contact phone number of LDSS staff member completing report

Quarters: Time period during which information is to be tracked by LDSS
Census Number : Enter number of authorized LTHHCP participants during quarter (time period)

1. **Number of LTHHCP applications and/or referrals for the LTHHCP:**
    a. Enter the number of all applications and/or referrals for individuals interested in LTHCHP. This number includes cases that may not be Medicaid eligible at time of LTHHCP application/referral.
    b. Enter the number of all applications and/or referrals **pending** related to matters such as acceptance of the referral, referral processing, discharge from institution, the individual is reviewing his/her choice of program or provider.

2. **Average length of time (calendar days) between LTHHCP applications and/or referrals for the LTHHCP and Level of Care (LOC) determination (Date of DMS-1 completion by LTHHCP Agency RN/Facility RN):** Enter the average calendar days between LTHHCP application and DMS-1 assessment completion date. If the completed DMS-1 form is the actual "referral/application" then the # of days would be 0 (zero).

3. **Number of LTHHCP applications approved:** Of the number or applications /referrals reported in #1 above, enter the number of applications that were authorized for LTHHCP participation.

4. **Number of LTHHCP applications denied:** Of the number or applications/referrals reported in #1 above, enter the number of applications that were denied LTHHCP participation.

5. **Number of LTHHCP reassessment visits made:** Enter the number of home visits conducted by LDSS for purposes of reassessment/completion of the Home Assessment Abstract.

6. **Number of participants disenrolled from the LTHHCP and reason:** Enter the total number of participants disenrolled from the LTHHCP. In the area below the total number, specify the number of disenrollments for each reason listed, for example: 6 total disenrolled; reasons for disenrollment: 3 Deaths; 3 Nursing Home Placements**. If the reason for disenrollment is not listed, enter the number and reason for disenrollment under "Other".**

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7. **Number of alleged occurrences of abuse, neglect, and/or exploitation requiring referral to APS/CPS.** Enter the total number of referrals made to APS/CPS for alleged occurrences of abuse, neglect, and/or exploitation; the number reported includes all referrals made for this purpose regardless of whether the complaint is substantiated.

8. **Number of total participants surveyed during this quarter *(this information relates to the Consumer Satisfaction Survey form requiring signature annually)***
   a. **Number of participants satisfied with the LTHHCP**
   b. **Number of participants satisfied with services in the LTHHCP**
   c. **Number of participants satisfied with the LTHHCP agency/staff**

   This information must be obtained by surveying LTHHCP participants on an annual basis as the LTHHCP Consumer Satisfaction Survey is completed (Refer to GIS 10LTC001) Enter the total number of participants surveyed during the quarter and enter the number of responses for each category as listed in a, b, and c above.

Completed report must be submitted within 15 days of the end of each quarter. Due Dates are listed next to each quarter. Reports may be emailed or faxed to the address as listed on the report.

LTHHCP LDSS Quarterly Report

County _____ Date: _____, 20__

Submitted by: _____ Phone #: _____

☐ Quarter 1	Period 1/01 – 3/31	Census #_____	Due DOH by 4/15
☐ Quarter 2	Period 4/1 – 6/30	Census #_____	Due DOH by 7/15
☐ Quarter 3	Period 7/1 – 9/30	Census #_____	Due DOH by 10/15
☐ Quarter 4	Period 10/1 – 12/31	Census #_____	Due DOH by 1/15

1. a. _____ # of LTHHCP applications and/or referrals for the LTHHCP

   b. _____ # of applications/referrals pending

2. _____ Average length of time (calendar days) between LTHHCP applications and/or referrals for the LTHHCP and Level of Care (LOC) determination (Date of DMS-1 completion by LTHHCP Agency RN/Facility RN)

3. _____ # of LTHHCP applications approved

4. _____ # of LTHHCP applications denied

5. _____ # of LTHHCP reassessment visits made

6. _____ # of participants disenrolled from the LTHHCP and reason

   Death: # _____ Hospital/Rehab: # _____ Participant Request: # _____ Moved: #_____

   Nursing Home Placement: # _____ No Longer Eligible - exceeds budget cap: # _____

   Other: # and reason_____

7. _____ # of alleged occurrences of abuse, neglect, and/or exploitation requiring referral to APS/CPS.

8. _____ # of total participants provided the Satisfaction Survey during this quarter

   a. _____ # of participants satisfied with the LTHHCP

   b. _____ # of participants satisfied with services received in the LTHHCP

   c. _____ # of participants satisfied with the LTHHCP agency/staff

Please return FORM to: DOH LTHHCP Waiver Management Staff
FAX: 518-474-7067 or Email: lwf03@health.state.ny.us

Questions: Contact DOH LTHHCP Waiver Management Staff at 518-474-5271.