# LTHHCP DSS Quarterly Report

County _____ Date: _____

Submitted by: _____ Phone #: _____

☐ Quarter 2 Period 4/1/09 – 6/30/09 Census #_____ Due DOH by 7/15/09 *(Field Test)*
☐ Quarter 3 Period 7/1/09 – 9/30/09 Census #_____ Due DOH by 10/15/09
☐ Quarter 4 Period 10/1/09 – 12/31/09 Census #_____ Due DOH by 1/15/10

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

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 surveyed during this quarter *(this info included on Consumer Information form requiring signature annually)*

   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: drj01@health.state.ny.us**

**Questions: Contact DOH LTHHCP Waiver Management Staff at 518-474-6580.**

## Instructions for completing LTHHCP DSS Quarterly Report

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

**Quarters:** Time period during which information is to be tracked by DSS
**Census #:** Enter # of authorized LTHHCP participants during quarter (time period)

1. **# of LTHHCP applications and/or referrals for the LTHHCP:** Enter the number of all applications and/or referrals for individuals interested in LTHCHP. This # includes cases that may not be Medicaid eligible at time of LTHHCP application/referral.

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

6. **# 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 # of disenrollments for each reason listed. (for example # 6 total disenrolled, reasons for disenrollment 3 Deaths, 3 Nursing Home Placement**). If the reason for disenrollment is not listed, enter the # and reason for disenrollment under "Other".**

7. **# of alleged occurrences of abuse, neglect and/or exploitation requiring referral to APS/CPS.** Enter the total # 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 it is substantiated.

**8. _____ # of total participants surveyed during this quarter** ***(this info included on Consumer Information form requiring signature annually)***

**d. _____# of participants satisfied with the LTHHCP**
**e. _____# of participants satisfied with services in the LTHHCP**
**f. _____# of participants satisfied with the LTHHCP agency/staff**

This information must be obtained by surveying LTHHCP participants on an annual basis as recorded on page 4 of the LTHHCP Consumer Information pamphlet. Enter the total # of participants surveyed during the quarter and enter the # of responses for each category as listed in d, e, and f.

**Completed report can be either emailed or faxed to address as listed on the report by the Due Date listed next to each quarter.**