Attachment A

Elderly Waiver Program Monthly Service Caps Effective 10/1/2007 – 9/30/2008

Elderly Waiver	
Case Mix	**Monthly Cap as of 10/1/2007**
A	**$2,231**
B	**$2,539**
C	**$2,978**
D	**$3,077**
E	**$3,393**
F	**$3,496**
G	**$3,608**
H	**$4,071**
I	**$4,178**
J	**$4,453**
K	**$5,190**

Elderly Waiver Percentages by Case Mix used to Determine CDCS Monthly Conversion Rates Effective 10/1/2007 – current

Elderly Waiver	
Case Mix	**%**
A	**50.00**
B	**51.89**
C	**51.32**
D	**53.48**
E	**61.03**
F	**60.65**
G	**59.19**
H	**67.24**
I	**76.02**
J	**72.94**
K	**64.38**

Attachment C

ELDERLY WAIVER CONVERSION RATE REQUEST

COUNTY INFORMATION/HEALTH PLAN INFORMATION

Contact:	
Address:	
FAX	Telephone:

CLIENT INFORMATION

Recipient:	Date of Birth:
PMI #	Date of Request:
Case Mix	**Cost of Care Plan**

Nursing facility where client resides:	
(Initial request - Attach the Medical Assistance remittance advice form showing client's NF per diem rate)	
Per diem rate: $_____ X 365 = _____ ÷ 12 =	$_____
Minus current maintenance needs allowance (as of 7/01/08 is $860)	$
Client's monthly cap limit	$

Health Plan Initial: Approved _____ Denied _____

Name of Managed Care Organization: _____
Signed: _____ Date _____
Comments:

DHS Initial: Approved _____ Denied _____	COLA Increase Approved:_____
Signed: _____	Date _____
Comments:	

EW FAX: **651-431-7415**
US MAIL ADDRESS: **Department of Human Services**
Aging and Adult Services Division
Po Box 64976
St. Paul, MN 55164-0976

Attachment D

ELDERLY WAIVER CDCS CONVERSION RATE REQUEST

COUNTY INFORMATION/HEALTH PLAN INFORMATION

Contact:	
Address:	
FAX	Telephone:

CLIENT INFORMATION

Recipient:	Date of Birth:
PMI #	Date of Request:
Case Mix	**Cost of Care Plan**

Nursing facility where client resides:	
(Initial request - Attach the Medical Assistance remittance advice form showing client's NF per diem rate)	
A) Per diem rate: $_____ X 365 = _____ ÷ 12 =	$_____
Multiply **A** above by the Case Mix Percentage to determine MAX monthly CDCS conversion rate _____	$
Client's monthly cap limit using CDCS	$

Health Plan Initial: Approved _____ Denied _____

Name of Managed Care Organization: _____
Signed: _____ Date _____
Comments:

DHS Initial: Approved _____ Denied _____	COLA Increase Approved:_____
Signed: _____	Date _____
Comments:	

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