

State of Connecticut
Department of Social Services
Request for an Increased Fee Pursuant to Section 17-b-242
C.G.S

Please complete the following and include all required materials. Forms and supporting documentation may be sent to the Department via fax transmission, email transmission as a PDF document, or by regular mail using the following contact information:

Department of Social Services
Reimbursement & CON
55 Farmington Avenue, 9th Floor
Hartford, CT 06105
Email: kathleen.shaughnessy@ct.gov
Fax: 860-424-4812

Date: _____ Cost Year: _____

1. Agency Information:

Agency Name: _____

Street Address: _____

City/Town, Zip Code: _____

Contact Name: _____

Contact Telephone: _____

Contact Email address: _____

2. Request for:

- a. AIDS Services (complete Form AS-1)
- b. Escort services (complete Form ES-1)
- c. High-Risk Maternal & Child Health Care (complete Form MCH-1)
- d. Extended Hour Services (complete Form EHS-1)

3. Include the following:

- a. Most recent filed Medicare annual cost report
- b. Any additional documentation requested by form to support your request

4. Important Notice:

- a. Add-ons must be re-applied for yearly prior to their expiration date of June 30th. Applications for add-ons must be received by May 1st for a July 1st effective date. Late applications will not be accepted.
- b. All supporting documentation indicated in Item #3 above must be included for review.

Department of Social Services
 AIDS Services Add-On-Skilled Nursing
 Form AS-1

Agency Name: _____

Cost Year: _____

A. Number of **skilled nursing visits**, hours, costs, average cost per visit, and average cost per hour for cost year specified:

<u>Payor</u>	<u>Visits</u>	<u>Hours</u>	<u>Cost</u>	<u>Average Cost per Visit</u>	<u>Average Cost per Hour</u>
Medicaid					
Medicare					
Total (Agency)					

B. Number of **home health aide** visits, hours, costs, average cost per visit, and average cost per hour for cost year specified:

<u>Payor</u>	<u>Visits</u>	<u>Hours</u>	<u>Cost</u>	<u>Average Cost per Visit</u>	<u>Average Cost per Hour</u>
Medicaid					
Medicare					
Total (Agency)					

C. Number of unduplicated Medicaid visits and hours, including those indicating a complication of end-stage AIDS:

		A		B		C	
		<u>Total Medicaid</u>		<u>Medicaid AIDS*</u>		<u>Extraordinary Costs Related to AIDS (B-A)**</u>	
	<u>Code</u>	<u>Hours</u>	<u>Costs</u>	<u>Hours</u>	<u>Costs</u>	<u>Hours</u>	<u>Costs</u>
RN	S9123						
RN	S9123 T1002(units)						
LPN	S9124						
LPN	S9124 T1003(units)						
RN	S9123 TG						
LPN	S9124 TG TE						
HHA	T1004 (units)						

***Include all services and costs for bills including diagnosis code 042**

****Please provide a brief explanation pertaining to extraordinary costs below:**

Department of Social Services
 Escort Services Add-On-Skilled Nursing /HHA
 Form ES-1

Agency Name: _____ Cost Year: _____

A. Personnel Costs:

<u>Salaries</u>		<u>FTEs</u>	<u>Total</u>
1	Drivers		
2	Security Guards		
3	Second Staff Persons		
4	Other (specify on Attachment)		
5	Subtotal (Lines 1 through 4)		
6	Employee Benefits Associated with above salaries		
7	Personnel Costs (Lines 5+6)		

B. Non-Personnel Costs:

		<u>Total</u>
1	Specify on Attachment	
2	Capital Related and Plant Operations (A5*.075)	
3	Non Personal Costs (1+2)	

Department of Social Services

Escort Services Add-On-Skilled Nursing /HHA

Form ES-1

- C. Total Escort Cost (A7 +B3): _____
- D. Total All Visits (SN, PT, SP, and OT): _____
- E. Requested Add-On per visit (C/D) for SN, PT, SP, and OT: _____

Home Health Aide (HHA) Add-on:

- 1. Per Visit Add-on (Line E): _____
- 2. HHA Visits: _____
- 3. HHA Add-on (1*2): _____
- 4. HHA Hours: _____
- 5. HHA Add-on Per Hour (3/4): _____
- 6. HHA Add-on Per Quarter Hour (5*.25): _____

Department of Social Services

Maternal & Child Health Add-On-Skilled Nursing

Form MCH-1

Agency Name: _____ Cost Year: _____

A. Number of all skilled nursing visits, costs, and average cost per visit for cost year specified:

<u>Payor</u>	<u>Visits</u>	<u>Hours</u>	<u>Cost</u>	<u>Average Cost per Visit</u>	<u>Average Cost per Hour</u>
Medicaid					
Total					

B. Number of Medicaid Skilled Nursing and Maternal & Child Health high risk visits, costs and average cost per visit for cost year specified:

<u>HCPCS Code</u>	<u>Visits</u>	<u>Hours</u>	<u>Cost</u>	<u>Average Cost per Visit</u>	<u>Average Cost per Hour</u>
S9123 Modifier TH (include T1002)					
S9124 Modifier TH (include T1003)					

Department of Social Services

Escort Services Add-On-Skilled Nursing

Form EHS-1

				<u>Nursing</u>	<u>Home Health Aide</u>
A.	Extended Hour Payroll Dollars				
B.	Extended Hour Fringe Benefits				
C.	Capital Related @ .075				
D.	Other Extended Hour Cost (Attach Detail Support)				
E.	Total Extended Hour Cost (A+B+C+D)				
F.	Actual Extended Hour Services			<u>Visits</u>	<u>Hours</u>
		1.	Extended Hour Services Visits or Hours		
		2.	Total Visits or Hours		
		3.	% Extended Hours Services (F1/F2)		
				<u>Nursing</u>	<u>Home Health Aide</u>
G.	Incremental Extended Hours Cost (E/F1)				
H.	Calculated Extended Hour Add-on per Quarter Hour (G*F3)			n/a	
I.	HHA Extended Hour Add-on per Quarter Hours			n/a	