



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

HOME AND COMMUNITY BASED SERVICES REFERRAL

PARTICIPANT NAME	DCN	PARTICIPANT TELEPHONE NUMBER
SPOUSE NAME	SPOUSE DCN	ALTERNATE TELEPHONE NUMBER
PARTICIPANT ADDRESS		PARTICIPANT COUNTY
FOR FSD USE ONLY		
FSD OFFICE Poplar Bluff HCB Processing Center	TELEPHONE NUMBER (573) 840-9200	DATE
ADDRESS 1903 Northwood Dr., Ste. 1, Poplar Bluff, MO 63901	EMAIL ADDRESS FSD.HCBinformation@dss.mo.gov	
COMMENTS		
PARTICIPANT REFERRED TO DHSS DUE TO FSD NEED OF ELIGIBILITY DETERMINATION FOR <input type="checkbox"/> HCB Medicaid <input type="checkbox"/> Division of Assets <input type="checkbox"/> Miller Trust		
FOR DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)		
DHSS STAFF NAME	TELEPHONE NUMBER	DATE
ADDRESS	EMAIL ADDRESS	
CLAIMANT REFERRED TO FSD FOR ELIGIBILITY DETERMINATION OF <input type="checkbox"/> HCB Medicaid <input type="checkbox"/> Division of Assets <input type="checkbox"/> Miller Trust		
CLAIMANT FOUND ELIGIBLE BY DHSS FOR <input type="checkbox"/> Nursing Facility Level of Care		EFFECTIVE DATE
COMMENTS		
FOR FSD USE ONLY		
FSD RESPONSE <input type="checkbox"/> Approved Division of Assets <input type="checkbox"/> HCB Ineligible, MHNSD, SLMB, still active or approved <input type="checkbox"/> Approved HCB <input type="checkbox"/> Miller Trust Approved <input type="checkbox"/> Rejected for MO HealthNet		DATE

Home and Community Based Services Referral Form (IM-54A) Instructions

PURPOSE: The Home and Community Based Referral (IM-54A) provides a standard form for interagency communication between the Department of Social Services, Family Support Division (FSD) and the Department of Health and Senior Services or their Designee regarding the Home and Community Based Medicaid program. For information on the HCB Medicaid program requirements see [0820.000.00 ELIGIBILITY BASED ON RECEIPT OF HCB WAIVER SERVICES](#).

NUMBER OF COPIES AND DISPOSITION: The original IM-54A is kept in the file of the originating agency and a copy goes to the receiving agency. The form is returned to the originating agency after a decision has been made, and the receiving agency will retain a copy.

INSTRUCTIONS FOR COMPLETION:

Participant Information:

Enter the participant's name, Departmental Client Number (DCN), telephone number, spouse's name, spouse's DCN, alternate phone number, county of residence, and mailing address.

For FSD Use Only:

- The FSD Eligibility Specialist (ES) will enter his/her name, telephone number, the date received, office address, ES email address, case carrying county, and ES load number.
- Provide any additional information in the "Comments" section that would be beneficial to DHSS when processing this referral.
- The FSD Eligibility Specialist will check the "HCB Medicaid" box when referring a brand new Home and Community Based Services participant to DHSS/Designee for determination of HCB Medicaid. The FSD ES will check the "Division of Assets" box when a married participant, currently receiving Home and Community Based Services, for continued eligibility for Medicaid benefits. The FSD ES will check the "Miller Trust" box referring a brand new participant for Miller Trust.

When the IM54A is completed by FSD

- For NEW referrals - participants not receiving Home and Community Based Services, fax or email the referral to the HCBS Call Center: (573) 526-2915, hcbsscallcenter@health.mo.gov.
- For redetermination referrals - participants currently receiving Home and Community Based Services, fax or email referral to the Regional Evaluation Team at:
 - Region 1: (417) 895-1341, REV1@health.mo.gov
 - Region 2: (573) 290-5650, REV2@health.mo.gov
 - Region 3: (314) 340-3467, REV3@health.mo.gov
 - Region 4: (816) 889-2004, REV4@health.mo.gov
 - Region 5: (573) 884-4884, REV5@health.mo.gov

Division of Senior and Disability Services HCBS Regional Evaluation Teams map may be found at:

<http://health.mo.gov/seniors/homecomservices/pdf/BHCS-EvalTeam.pdf>

For DHSS/Designee:

- The DHSS/Designee will enter his/her name, telephone number, the date received, the office address, and email address of the DHSS/Designee.
- Claimant referred to FSD for: Check the appropriate box (HCB Medicaid, Division of Assets, or Miller Trust) to inform FSD of the purpose of the referral.
- Claimant found by DHSS/designee to require: If the participant is eligible for HCBS, check the appropriate box and provide the effective date.
- Claimant found ineligible by DHSS for: Check the appropriate box if the participant is found to be ineligible for any HCBS authorized by DHSS.
- Provide any additional information in the "Comments" section that would be beneficial to FSD when processing this referral.

FSD Response:

- Check the appropriate box after the approval/denial is returned from DHSS to display participant's eligibility; denied/approved for benefits.