

Client Information Update



Section 1

<input type="checkbox"/> Disabled & Elderly <input type="checkbox"/> Medically Fragile <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Brain Injury <input type="checkbox"/> Institutional Care <input type="checkbox"/> Other :	
Today's Date:	Client Name:
To:	Date of Birth:
Submitted by: Name, agency, email, phone:	ID Number:

Section 2

<input type="checkbox"/>	Application Status	Status:
<input type="checkbox"/>	Address Change of	New Address:
<input type="checkbox"/>	Change of	New Information:
<input type="checkbox"/>	Level of Care	Dates: To:
<input type="checkbox"/>		Dates: To:
<input type="checkbox"/>	Allocation on Hold	Date requested:
<input type="checkbox"/>	Reason:	Date of Denial/Closure:
<input type="checkbox"/>		Dates: To:
<input type="checkbox"/>	Deceased	Date of Death:
<input type="checkbox"/>		Date of Admission:
<input type="checkbox"/>	Nursing Facility Name:	Date of Discharge:
<input type="checkbox"/>		Date of Admission:
<input type="checkbox"/>	Hospital Facility Name:	Date of Discharge:
<input type="checkbox"/>	Moved Out of State:	Last date of NM Residency, if known:
<input type="checkbox"/>	Incarceration	Date and Expected Length of Incarceration:
<input type="checkbox"/>	Request Setting of Care Change	Effective Date(s) of Change:
<input type="checkbox"/>	Request for ISD COE Extension Include reason in Comment(s).	Extension Dates:
<input type="checkbox"/>	Waiver Services Not Accessed (60 Day Rule)	Enter last date of Waiver Services:
<input type="checkbox"/>	Other/Comments:	

Section 3

Date of Action:	Response completed by (Name and Agency):
Response:	

Important: When action is completed, Please return this form to the Submitter within 5-7 business days.

Client Information Update

Instructions

Purpose: The Client Information Update Form is a tool for internal communication among the following: Income Support Division (ISD); Human Services Division/Medical Assistance Division (HSD/MAD); Managed Care Organizations (MCO); Third Party Assessor (TPA); Case Management Agencies; Consultant Agencies; Support Brokers and partnering state agencies.

Section 1: Check appropriate Program/Service box, enter the date. To: who the CIU is intended for, Submitter Information and Medicaid recipient information including client name, date of birth and ID number. (The ID number may be the social security number, Medicaid ID, Aspen MCI ID.)

Section 2: Status Update

Application status: Check this box if inquiring on an application status. Select appropriate option from drop down list, (Open, Denied or Pending. Responder can also select from the drop down menu when responding to the question of a Status.)

Change in Client Address: Check this box and select appropriate option from drop down list, (Client, Guardian, and Authorized Representative). Enter New Address.

Change of Case Management Agency/Consultant Agency/Care Coordinator/Support Broker: Check this box if you are updating a change. Select appropriate option from drop down list and enter New Information including new address and phone number.

Level of Care: Check this box. Enter start and end dates of current Level of Care.

Allocation/Transition: Check this box if inquiring on a waiver allocation or a transition. Select appropriate option from drop down list, Allocation or Transition.

Allocation/Transition Dates: Enter start and end dates of the allocation or anticipated transition dates. (If additional information is needed for anticipated start and end dates, enter in the comments section.)

(DDW only)Allocation on Hold: Check this box if participant has chosen to hold their allocation (DDW only) and enter date requested.

Denial/Closure Reason: Check this box and select appropriate option from drop down list, (Denial, Closure). Enter date. (If additional information is needed for Denial/Closure enter in the comments section.)

Plan of Care/ISP/SSP Dates: Check this box. Enter start and end dates of current Plan of Care/ISP or SSP.

Deceased: Check this box and enter the date of death. Attach written proof of date of death if possible.

Nursing Facility: Check this box and enter the admission/discharge date, as applicable.

Hospital Facility: Check this box and enter the facility name. Enter the admission/discharge date, as applicable.

Moved Out of State: Check this box if client moved out of state and enter the last date of NM residency if known.

Incarceration: Check this box and enter the date and expected length of incarceration.

Request Setting of Care Change: Check this box and include the reason for Setting of Care change in the Comment section. Enter the effective date of change.

Request for ISD COE Extension: Check this box and include the reason in the Comment section, if requesting ISD to keep

the COE open. Enter dates.

Waiver Services Not Accessed: Check this box if the waiver recipient has not received waiver services for 60 days or more. Enter the last date of waiver services.

Other/ Comments section: Check this box and enter additional information as it pertains to the Status Updates above. Include any information to verify the request, including attachments if available. This box can also be used to request specific information not listed in section 2.

Section 3:

Date of Action: Recipient of form must enter the date completed.

Response Completed By: Enter name and entity to verify action is complete. When action is completed, return the form to the Submitter within 5-7 business days.

Response: Recipient of form will enter response to the inquiry.