REQUEST TO EXCEED CASE MIX CAP
MSHO and MSC+

Form must be completed by UCare Care Coordinator

Incomplete, illegible or inaccurate forms will be returned to sender. All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.

Date of Request:

CARE COORDINATOR INFORMATION

Care Coordinator: _____

Email Address: _____ Care System: _____

Telephone Number: _____ Fax Number: _____

MEMBER INFORMATION

Member Name: _____

Date of Birth: _____ UCare ID: _____

Case Mix: _____ Case Mix Cap Amount: $_____

Requested Total Monthly Amount over Case Mix Cap: $_____

LTCC Assessment Date: _____ EW Date Span: _____ - _____

PCA Assessment Date: _____ Number of Units/Hours Daily: _____

Home Care Nursing (Private Duty Nursing) Hours Daily: _____

Please indicate options that have been considered in order to stay under the case mix cap: (e.g. Reduce other services and what are the effects on member's health?)

Additional information regarding this request and justification to exceed case mix cap:

The following documentation must be included with each request.

☐ LTCC/MNCHOICES assessment ☐ Budget worksheet ☐ Customized Living or foster care rate tool, if applicable

☐ Other supporting documents deemed appropriate

To reach Clinical Services or to send completed forms: Phone: 612-676-6705 **Fax Line**: **612-884-2499**
Toll Free Fax: 866-610-7215

people powered health plans

REQUEST TO EXCEED CASE MIX CAP
MSHO and MSC+ FORM INSTRUCTIONS

Completing entire form will ensure timely processing. Please allow up to 14 calendar days for UCare to receive, review and process.

CARE COORDINATOR INFORMATION

Date of Request: Date the form was completed
Care Coordinator: Name of Care Coordinator making determination
Email: Care Coordinator's email address
Care System: Name of delegated care system
Phone/Fax: Care Coordinator's phone and fax number

MEMBER INFORMATION

Member Name: Full correct spelling of member's name
DOB: Member's date of birth
UCare ID: Member's 11 digit UCare ID Number (information is required)

Case Mix: Member's current case mix
Case Mix Cap Amount: Member's current monthly case mix dollar amount
Requested total monthly amount over case mix cap: Dollar amount requested that would exceed member's currently monthly cap.
LTCC Assessment Date: Current or most recent LTCC Assessment date.
EW Date Span: Elderly Waiver date span
PCA Assessment Date: Current or most recent face to face PCA Assessment date.
Number of Units/Hours daily: Number of units/hours of PCA approved daily
Home Care Nursing (Private Duty Nursing) Hours Daily: Number of hours approved under HCN/PDN Daily

Please indicate options that have been considered in order to stay under case mix cap: ***PROVIDE DETAIL EXPLANATION***
A few things to note in this area includes what options have you thought of when determining that exceeding case mix cap is appropriate for member to remain in the community. Examples include:

- Considered the reduction of PCA/HCN services and include how it would affect the member's health.
- Considered the reduction other waiver services and include how it would affect the member's health.
- A change in condition LTCC/PCA Assessment was completed and it DID NOT determine that member meets a higher case mix cap.

Add information regarding this request and justification to exceed case mix cap: ***PROVIDE DETAIL EXPLANATION***

The following documentation must be included with each request: All documentation must accompany your request upon submission to UCare. Any missing information will not be processed and may result in returned request for additional or missing information.

To reach Clinical Services or to send completed forms:

Phone: 612-676-6705 **Fax Line**: 612-884-2499 **Toll Free Fax**: 866-610-7215