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. **All Applicants Must Complete General Form In Addition to Applicable Forms Listed Below:**
   a. AIDS Services (complete Form AS-1)
   b. Escort services (complete Form ES-1)-Visits requiring Security Accompaniment
   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

This Form Must be

Completed for Any Add-On Request Category

General Form

Agency Name: _____ Cost Year End: _____

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

Payer	Visits	Hours	Cost	Average Cost per Visit	Average Cost per Hour
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:

Payer	Visits	Hours	Cost	Average Cost per Visit	Average Cost per Hour
Medicaid					
Medicare					
Total (Agency)					

Department of Social Services

AIDS Services Add-On-Skilled Nursing /HHA

AS-1

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

		A		B		C	
		Total Medicaid		**Medicaid AIDS***		**Extraordinary Costs Related to AIDS (B-A)****	
	Code	Hours	Costs	Hours	Costs	Hours	Costs
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: _____

A. Personnel Costs:

	Salaries	**FTEs**	**Total**
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:

		Total
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 (cont.)

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: _____

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

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

Department of Social Services

Extended Hour Services Add-On-Skilled Nursing/HHA

Form EHS-1

				Nursing	Home Health Aide
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			**Visits**	**Hours**
		1.	Extended Hour Services Visits or Hours		
		2.	Total Visits or Hours		
		3.	% Extended Hours Services (F1/F2)		

		Nursing	Home Health Aide
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	