STATE OF CONNECTICUT

Department of Social Services

W-1696
(Rev. 04/19)

Patient Liability Change Report

Patient's Full Name: Last _____ First _____ M ____

Medicaid Client ID: _____ **Case Number:** _____

Month Facility Began Collecting Proposed PLA	Current PLA	Proposed PLA

Explanation: _____

_____

_____

INCOME SOURCES	Month(s):	Month(s):	Month(s):
Social Security			
Pension 1			
Pension 2 / Annuity			
Other			
ALLOWABLE DEDUCTIONS			
Personal Needs Allowance			
Medicare B Premium			
Medicare D Premium			
Spousal/Family Allowance			
Private Health Insurance Premium 1			
Private Health Insurance Premium 2			
Short Term Rental Diversion			
Medical Diversion			

Type of Provider: ☐ Nursing Facility (SNF) ☐ Nursing Facility (ICF)

☐ ICF/IID ☐Chronic Disease Hospital

Provider Number: _____

Provider Name: _____

Provider Address: _____

_____

Completed By (please PRINT): _____

Phone Number: _____

Email Address: _____

Date Completed: _____

Instructions to Facilities for W-1696

1. Insert the patient's **FULL NAME**; Last, First, and Middle Initial
2. Insert the patient's Medicaid **Client ID** Number – This is the nine-digit number used to identify the individual.
3. Insert the patient's **Case Number**, if known.
4. Insert the following information:
    - **Month Facility Began Collecting Proposed PLA** – this is the month that you began collecting the PLA that you proposed.
    - **Current PLA** – this is the current Patient Liability Amount.
    - **Proposed PLA** – this is the Patient Liability Amount you are proposing.
5. Include an **explanation** regarding the change. Was there a change in income or allowable deductions? When did it begin? **Attach PROOF** of the income or deduction change, and documentation verifying WHEN this change occurred, as this may be different from the month it was collected by you. The direct deposit is not proof of the gross amount. (Failure to provide such proof will delay the Department's processing)
6. Use the chart provided to list the changes you are reporting. It is not necessary to list any information that has not changed. *For example, if you are reporting an increase in a pension effective 07/2018, you would list "07/2018 – present" at the top of the column, and then list the gross amount in the corresponding row.*
7. Check appropriate box to indicate the **type** of facility.
8. Insert the provider's 10-digit **Provider Number**.
9. Fill in the **Provider's name**.
10. Fill in the **Provider's address** (physical location of the facility). Include Zip + 4.
11. Print your name in the "**Completed By**" field.
12. List the best **phone number** to reach the designated contact person, should the Department have any questions.
13. List the **email address** of the contact person.
14. List the **date** you completed this form.
15. If this form is for a pending application, you can mail this form directly to the assigned application staff member.
    If this is to report a change and the client listed has a MyAccount set up, this can be uploaded online.
    If this is to report a change and the client listed does NOT have a MyAccount set up, mail this form to the: **DSS ConneCT Scanning Center**
    PO Box 1320
    Manchester, CT 06045-1320