# FORMS

| Number | Name | Revision Date |
|---|---|---|
| DHHS 126 | Confidential Complaint | 06/2007 |
| DHHS 205 | Medicaid Refunds | 01/2008 |
| DHHS 931 | Health Insurance Information Referral Form | 02/2018 |
| | Electronic Funds Transfer (EFT) Authorization Agreement | 08/2017 |
| | Duplicate Remittance Advice Request Form | 09/2017 |
| | Claim Reconsideration Form | 11/2018 |
| | Sample Remittance Advice (two pages) | |
| 181 | Authorization Form 181 with Instructions (two pages) | 05/2018 |
| 235 | Request for Approval of Non-Covered Medical Expenses | 07/2008 |
| 236 | Log of Incurred Medical Expenses (two pages) | 07/2008 |
| 185S | Complex Care Supplemental Assessment Form (two pages) | 09/2017 |
| 247 | Social History for MI Level II PASARR Screening (two pages) | 04/2017 |
| 248 | Social History for ID Level II PASARR Screening (two pages) | 04/2017 |
| 249 | PASARR Referral Packet Cover Letter | 05/2007 |
| 250 | Psychiatric Evaluation Level II (three pages) | 01/1992 |
| 185 | Level of Care Certification Letter (two pages) | 11/2003 |
| 121 | Consent Form | 06/2003 |
| 234 | PASARR Level I Screening Form (two pages) | 04/2017 |
| 210 | Resident Case Mix Classification Change (two pages) | 04/2017 |
| 1231 ME | Request for Assessment of Level of Care | 06/2003 |
| | PFAs Core Curriculum — Attachment B (two pages) | |

**STATE OF SOUTH CAROLINA**
**DEPARTMENT OF HEALTH**
**AND HUMAN SERVICES**

# CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

## PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

| | |
|---|---|
| NPI or MEDICAID PROVIDER ID: (if applicable) | MEDICAID RECIPIENT ID NUMBER: (if applicable) |
| ADDRESS OF SUSPECT: | LOCATION OF INCIDENT: |
| | DATE OF INCIDENT: |

COMPLAINT:

| | | |
|---|---|---|
| NAME OF PERSON REPORTING: (Please print) | SIGNATURE OF PERSON REPORTING: | DATE OF REPORT |

| | |
|---|---|
| ADDRESS OF PERSON REPORTING: | TELEPHONE NUMBER OF PERSON REPORTING: |
| | SIGNATURE: (SCDHHS Representative Receiving Report) |

**South Carolina Department of Health and Human Services**
**Form for Medicaid Refunds**

**Purpose:** This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

**Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.** **Attach appropriate document(s) as listed in item 8.**

**1. Provider Name:** _____

**2. Medicaid Legacy Provider #** ☐☐☐☐☐☐
(Six Characters)

**OR**

**3. NPI#** ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

**4. Person to Contact:** _____ **5. Telephone Number:** _____

**6. Reason for Refund:** [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

**7. Patient/Service Identification:**

| Patient Name | Medicaid I.D.# (10 digits) | Date(s) of Service | Amount of Medicaid Payment | Amount of Refund |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**8. Attachment(s):** [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

# SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
# MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

**I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS**

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

**II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS**

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

**ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.**

Submit this information to Medicaid Insurance Verification Services (MIVS).

**Fax:** 803-252-0870 **or** **Mail:** Post Office Box 101110, Columbia, SC 29211-9804

**South Carolina Department of Health and Human Services**
***Electronic Funds Transfer (EFT) Authorization Agreement***

## PROVIDER INFORMATION

**Provider Name** _____

Doing Business As Name (DBA) _____

**Provider Address**
Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

**Provider EFT Contact Information**
Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

## FINANCIAL INSTITUTION INFORMATION

**Financial Institution Name** _____

**Financial Institution Address** _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

**Financial Institution Routing Number** _____

**Type of Account at Financial Institution** (select one) ☐ Checking ☐ Savings

**Provider's Account Number with Financial Institution** _____

**Account Number Linkage to Provider Identifier** (select one)
☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

**REASON FOR SUBMISSION:** ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

***All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.***

**Written Signature of Person Submitting Enrollment** _____

**Printed Name of Person Submitting Enrollment** _____

**Submission Date** _____

*TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:*

**Department of Health and Human Services**
**Medicaid Provider Enrollment**
**P.O. BOX 8809, COLUMBIA, S.C. 29202-8809**
**FAX (803) 870-9022**

**SPECIAL INSTRUCTIONS**: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

## South Carolina Department of Health and Human Services
## Duplicate Remittance Advice Request Form

**Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.**

**Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.**

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   _____
   _____
   _____
   _____
   _____

   **Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.**

5. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

**I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.**

_____ _____

**Authorizing Signature** **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

*Submit your Claim Reconsideration request to:*

**Fax:** 1-855-563-7086
or
**Mail:** South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

# CLAIM RECONSIDERATION FORM

**Instructions:** Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

**Section 1: Beneficiary Information**

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

**Section 2: Provider Information**

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
*Street or Post Office Box* *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

**Section 3: Claim Information** *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

**Section 4: Claim Reconsideration Information**

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

**Section 5: Desired Outcome**

**Request submitted by:**

Print Name: _____

Signature:_____ Date: _____

# Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle, and a rejected claim.

```
   PROVIDER ID.      000000000                                  REMITTANCE ADVICE            PAYMENT DATE                  PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                        +------------+                +----+
| 0123NF       |                                                NURSING CARE SERVICES      | 05/04/2007 |                |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                         +------------+                +----+

+---------+-----------------+------+-----------+-----+-----+--------+-+----------+-------------------+-------+-------+------+-----+
|PROVIDERS|      CLAIM      |      | SERVICE RENDERED|AMNT.|TITLE 19|S|RECIPIENT |RECIPIENT NAME      |PATIENT|BG END| INSTN| PATNT|
| OWN REF.|    REFERENCE    |      |   PERIOD  | CODE| OF  | PAYMENT|T|   ID.    |                 F M|MED EXP|SERVCE| DAILY| DAILY|
|  NUMBER |      NUMBER     |      |MMDDYY-MMDD|L DYS|BILL |MEDICAID|S|  NUMBER  |LAST NAME        I I|&INCOME|DATES | RATE | RATE |
+---------+-----------------+------+-----------+-----+-----+--------+-+----------+-------------------+-------+-------+------+-----+
|         |                 |      |           |     |     |        | |          |                   |       |      |      |      |
|         |0425700632135900G|      |           |    0|     | 4029.29|P|0000011000|DOE              J J|       |      |      |      |
|         |              01 |      |120106-1201|2  31|     | 4029.29|P|          |                   | 155.91| 1   1|135.02|129.88|
|         |                 |      |           |     |     |        | |          |                   |       |      |      |      |
|         |VOID OF ORIGINAL CCN 0507300410360000G PAID 20050318     | |          |                   |       |      |      |      |
|         |0507300410136000G|      |           |    0|     | -805.00|P|0000011000|DOE              J J|       |      |      |      |
|         |              01 |      |020107-0201|1  28|     | -805.00|P|          |                   |2975.56| 1   1|135.02| 28.75|
|         |                 |      |           |     |     |        | |          |                   |       |      |      |      |
|         |REPLACEMENT OF ORIGINAL CCN 0507300410136000G PAID 20050318|          |                   |       |      |      |      |
|         |0509700048600100G|      |           |   28|     |  750.96|P|0000011000|DOE              J J|       |      |      |      |
|         |              01 |      |020107-0228|1  28|     |  750.96|P|          |                   |3029.64| 1  28|135.02| 26.82|
|         |                 |      |           |     |     |        | |          |                                   |
|         |0503100163132500G|      |           |    0|     |    0.00|R|0000011000|DOE              J J|       |      |      |      |
|         |              01 |      |112406-1128|6   5|     |    0.00|R|          |                   |       |24  28|      | 94.47|
|         |                 |      |           |     |     |        | |          | EDITS:  L00 673          L00 156                |
|         |                 |      |           |     |     |        | |          |                   |       |      |      |      |
|         |                 |      |           |     |     |        | |          |                   |       |      |      |      |
|         |           TOTALS|      |CLAIMS    3|    0  0.00   3975.25 |          |                   |       |      |      |      |
|         |                 |      |           |     |     |        | |          |                   |       |      |      |      |
+---------+-----------------+------+-----------+-----+-----+-+------+-+----+-----+-------------------+-------+------+------+------+
                                          |      $0.00  | |     $3975.25 |
                                          +-------------+ +--------------+    STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                  SCHAP PG TOT     MEDICAID PG TOT                     +---------------------------------+
ERROR CODES LISTED ON THIS                +--------------+  +--------------+                     |ACME NURSING FACILITIES          |
FORM REFER TO:  "MEDICAID                 |              |  |    $3975.25  |   P = PAYMENT MADE  |P O  BOX 000000                  |
PROVIDER MANUAL".                         +--------------+  +--------------+   R = REJECTED      |                                 |
                                           SCHAP TOTAL      MEDICAID TOTAL    S = IN PROCESS    |ANYWHERE           SC 00000-0000 |
IF YOU STILL HAVE QUESTIONS                                 +--------------+   +---------+       |                                 |
PHONE THE D.H.H.S. NUMBER                                   |              |   |         |       +---------------------------------+
SPECIFIED FOR INQUIRY OF                                    +--------------+   +---------+
CLAIMS IN THAT MANUAL.                                        CHECK TOTAL     CHECK NUMBER
```

# Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a final page with a claim-level Adjustment without a corresponding Replacement claim.

PROVIDER ID. 000000000
0123NF

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 05/04/2007



| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | PY IND | SERVICE RENDERED DATE(S) MMDDYY | PROC. | AMOUNT BILLED | TITLE 19 PAYMENT MEDICAID | S T S | RECIPIENT ID. NUMBER | RECIPIENT NAME LAST NAME | F I | M I | M O D | ORG CHECK DATE | ORIGINAL CCN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0509420344031700U | | | | | | -1044.12 | P | 0000011000 | DOE | J | J | | 050318 | 05730037623600G |
| TOTALS | | | 00001 | | | -1044.12 | | | | | | | | |

| MEDICAID TOTAL | CERTIFIED AMT | | TO BE REFUNDED IN THE FUTURE |
|---|---|---|---|
| $3975.25 | 0.00 | 0.00 | 0.00 |

DEBIT BALANCE PRIOR TO THIS REMITTANCE

ADJUSTMENTS

| ADJUSTMENTS | |
|---|---|
| -979.88 | 0.00 |

YOUR CURRENT DEBIT BALANCE

| CHECK TOTAL | CHECK NUMBER |
|---|---|
| 2995.37 | 12424579 |

PROVIDER NAME AND ADDRESS

ACME NURSING FACILITIES
P O BOX 000000
ANYWHERE SC 00000-0000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections MEDICAID

# Notice of Admission, Authorization & Change of Status for Long Term Care

things to know

## General Information

DHHS FORM 181 is utilized by Nursing Facilities (NF's), Intermediate Care Facilities For Individuals with Intellectual Disability (ICF/IID's), Swing-Bed Hospitals (SB's), and/or SCDHHS Medicaid Eligibility Workers. The DHHS FORM 181 is authorization by the Department of Health and Human Services for payment and reimbursement for NF, ICF/IID, and SB services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider Services. **A DHHS FORM 945 should accompany all retroactive determinations over one year old for eligibility or recurring income.**

## Detailed Instructions

**A. Section I – Identification of Provider and Patient:**

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 7. This suffix (either alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card). The Provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider number.**

**B. Section II – Type of Coverage and Statistical Data:**

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in level of care changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates. Level of care must be reported on all DHHS Form 181s.

**For Authorization, send Form 181 to:** SCDHHS Central Mail
PO Box 100101
Columbia, SC 29202

**Fax:** (888) 820-1204

If the recipient has a non-covered medical expense, complete Forms 235 and 236. Send completed forms, if applicable, to: SCDHHS Division of Policy and Planning
PO Box 8206
Columbia, SC 29202-8206.

For Complex Care Terminations fax to SCDHHS Nursing Facility Service: (803) 255-8209.

**C. Section III – Authorization and Change of Status:**

**Only the SCDHHS Medicaid Eligibility Worker is responsible for the completion of this section.** The SCDHHS Medicaid Eligibility Approval Authority/Supervisor or a SCDHHS authorized representative must sign and date each form for all new admissions, income changes, and discharges home that affect income liability.

## Co-Insurance

In the case of filing for Medicare Coinsurance, a SNF Authorizing DHHS FORM 181 must be completed for each Medicare spell of illness. Coinsurance periods are billed using a copy of the initial signed authorization. Coinsurance dates must be supported by EOMBs; must not cross a calendar month; and the service dates must be consecutive.

The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly billing. **NOTE:** Effective with dates of service 12/01/01, DHHS no longer reimburses nursing facilities or ICFs/IID for Part A SNF coinsurance. Swing Bed Hospitals are paid coinsurance. **Coinsurance claims should never be sent with the monthly billing.**

## Distribution, Preparation and Routing of Form

The Provider of services will normally initiate these forms. The SCDHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The Provider of services must forward the forms to the appropriate SCDHHS Medicaid Eligibility Worker only when signature authorization in Section III is required.

A. Copy — Submitted by Provider for claims processing at MCCS.
Copy — Retained and kept on file by SCDHHS Medicaid Eligibility.
Original — Retained and kept on file by the Provider of services.

B. The Provider of services must attach a copy of this form to the current month's billing for each change in the status of a patient. Staple all 181 forms together for each patient.

Mailing address for end of month claims: MEDICAID CLAIMS RECEIPT - NF CLAIMS SECTION
POST OFFICE BOX 100122
COLUMBIA, SOUTH CAROLINA 29202-3122

Overnight delivery address: MCCS-NF-AW-220
CLAIMS RECEIPT - NF CLAIMS SECTION
8901 FARROW ROAD
COLUMBIA, SC 29203 -8930

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

# Notice of Admission, Authorization, and Change of Status for Long Term Care

*Must Be Typed or Completed in Blue or Black Ink*

**Provider Fax Number:**

**Hospice enrolled on or before admission:** ☐ (Check if Yes)

RESET FORM

**Income Trust?** ☐

## Section I. Identification of Provider and Patient (Completed by Provider/Facility)

| | | |
|---|---|---|
| 1. Beneficiary Name (First, Middle, Last) | 2.Birth Date (MO-DY-YY) | 3. Medicaid No. (10 digits) |
| 4. Facility Name | 6.County of Residence | 7. Social Security No. - HIB Suffix |
| 5. Facility Street Address | 8.Provider Medicaid ID | 9. Date of Request |
| City / State / ZIP | | |

| | | | |
|---|---|---|---|
| 10. Authorized Representative's Name | 12. Authorized Representative's Street Address | | |
| 11. Authorized Representative's Phone No. | City | State | ZIP |

**This Box for DDSN Therapy Wages Only:** ☐ Start ☐ Significant Change $ ☐ Stop Effective Date

## Section II. Type of Coverage and Statistical Data

13. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☐ SKILLED CARE (LOC1) ☐ INTERMEDIATE CARE (LOC2) ☐ SNF COINSURANCE (MEDICARE LOC6)

(B) CHANGE IN TYPE OF CARE: FROM - TO - DATE: (MO-DY-YY)

(C) ADMITTANCE DATE FOR: - DATE:

(D) TRANSFERRED - - (MO-DY-YY) (NAME OF OTHER FACILITY)

(E) READMITTED FROM HOSPITAL STAY: (MO-DY-YY)

(F) NUMBER OF DAYS ABSENT FROM FACILITY: COVERED DAYS:

(G) TERMINATION DATE: DATE OF DEATH (MO-DY-YY) ☐ RETURNED HOME (NOTIFY ELIGIBILITY)

(H) COINSURANCE DATES THIS BILL FROM (MO-DY-YY) THROUGH (MO-DY-YY) NO. OF DAYS:

(I) NON-COVERED MEDICAL EXPENSE: AMOUNT: ☐ FORM 236 ATTACHED

(J) ACTION: - DATES OF SERVICE: THRU

ACTION: - DATES OF SERVICE: THRU

COMMENTS:

## Section III. Authorization and Change of Status (Completed by DHHS EEMS Only)

14. Recommendation of SCDHHS Medicaid Eligibility Worker

(A) Authorization to Begin Date: (MO-DY-YY) (B) Applicant not qualified for long term care because: Financial Criteria Not Met ☐ Non-Financial Criteria Not Met ☐

(C) Beneficiary's Initial Applicable Recurring Income (Total Income Less Personal Allowance) $

(D) Change in Beneficiary Income (Total Income Less Personal Allowance) $ (MO-YYYY)

(E) Financially eligible, but waiting to be placed in a nursing home ☐

(F) Personal Needs Allowance $

(G) Other:

## Section IV– Signature

| Name of Eligibility Worker (Print) | Eligibility Worker Signature | Date |
|---|---|---|
| | | |

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

# Request for Approval of Non-Covered Medical Expenses

FROM: _____
_____
_____
_____
(Name & Address of Facility)

TO: South Carolina Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, South Carolina 29202-8206

Regarding: _____ _____
(Beneficiary's Name) (Medicaid ID#)

## Part I

(To be completed by facility)

Description of item/service received:
_____
_____
_____

Reason item/service is a questionable deduction or needs prior approval:
_____
_____
_____

Cost of item/service:
_____

## Part II

(To be completed by SCDHHS)

Item/Service approved for deduction:
☐ Yes ☐ No (check one)

If Yes, $ _____ may be deducted.

Signature: _____ Date: _____
Division of Medicaid Policy and Planning

SCDHHS Form 235 (Rev. 07/08)

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

# Log of Incurred Medical Expenses

## For the Month of _____

A brief description of expenses which can be deducted, including the limits, is found on the back of this form.

**Beneficiary's Name:** _____

**Medicaid ID Number:** _____

**Month:** _____

| Item/Service | Date Rendered | Date Bill Provided to Facility | Amount Billed for Item/Service | Lesser of Cost or Allowable Deduction |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | **Total** | | |

**Monthly Recurring Income (SCDHHS Form 181)** _____

**Incurred Monthly Expenses** _____
(Not to Exceed Monthly Recurring Income)

**Amount carried over to next month**** _____

*If actual cost is less than the limit found on the back of this form, enter actual cost. If actual cost is greater than the limit, enter the limit amount.

**If incurred monthly expenses exceed monthly recurring income, the difference can be carried forward to the next month. Put the difference on the first line of next month's log sheet. Include the statement "Prior Month Carry Forward" in the item/service line and the amount to be carried forward in the "Lesser of Cost or Allowable Deduction" column.

**The following deduction amounts outlined replace amounts determined in 1989:**

1. Eyeglasses
   - Not otherwise covered by the Medicaid program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee; and
   - A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.

2. Dentures
   - A one-time expense;
   - Not to exceed $651.00 per plate or $1320.00 for one full pair of dentures; and
   - A licensed dental practitioner must certify necessity.
   - An expense for more than one (1) pair of dentures must be prior approved by State Office.

3. Denture Repair
   - Not to exceed $77.00 per occurrence; and
   - A licensed dental practitioner must certify the necessity for denture repair.

4. Physician and other medical practitioner visits that exceed the yearly limit
   - Not to exceed $69.00 per visit.

5. Hearing Aids
   - A one-time expense;
   - Not to exceed $1000.00 for one or $2000.00 for both; and
   - A licensed practitioner must certify the necessity for hearing aids.
   - An expense for more than one hearing aid must be prior approved by State Office.

6. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

7. Other non-covered medical expenses which are recognized by State Law but not covered by Medicaid, or any other third party, not to exceed $20.00 per item/service. These non-covered medical expenses must be prescribed by a licensed practitioner.

Items/services presented by the beneficiary for deductions which require prior approval or are questionable should be submitted to the Division of Medicaid Policy and Planning. The request for prior approval should be made on the SCDHHS Form 235 and should be mailed to:

South Carolina Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, South Carolina 29202-8206

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMPLEX CARE PROGRAM SUPPEMENTAL ASSESSMENT FORM

**Contact Email: Complexcare@scdhhs.gov or Fax: (803) 255-8209.**
**Check status of applications by 5th business day.**

Applicant_____ Medicaid #_____

Name & Title of Staff Completing Form_____ Fax/Email _____

2nd Staff Contact Name & Title_____ Fax/Email_____

Facility Completing Form_____ Date Completed:_____

| **Initial Referral** ☐ | **Recertification** ☐ **Requested Recertification dates: To**_____**From** _____ |
|---|---|

**Submit initial referral when applicant is in hospital/acute inpatient for 10 consecutive days. Inpatient Admission date:** _____

**Check Applicants Insurance:** ☐ **Medicaid** ☐ **Medicare A** **Medicare #** _____

| Category/Treatment | Additional Information | Documents to send with referral |
|---|---|---|
| **Circle/fill in categories that apply to the applicant. Send admit note/H&P, Insurance carrier(s), and supportive documents.** | | |
| ☐ **Stage 4 /pressure ulcer only** | **(Attach staging note of stage 4 pressure wound only)** | |
| ☐**Tracheostomy** | ☐ **Tracheostomy tube/cannula**<br>☐**Tracheal cleaning** | **(Attach tracheostomy care/suction orders)** |
| ☐**Oral Suctioning**<br>**By respiratory care unit or nursing facility staff** | **Purpose:**<br>**Frequency** _____ | **(Attach care/suction note if applicable)** |
| ☐**Total Parenteral Nutrition**<br>☐**Partial Parenteral Nutrition**<br>Given by IV- Intravenous access only, No Antibiotics | ☐**Expected duration of 2 weeks or more**<br>**Name of TPN/PPN nutrition therapy:** _____ | **(Attach Medication list/orders for TPN/PPN therapy)** |
| ☐**Disruptive Behaviors 60% of the time requiring 1:1 assistance or restraints** | **List conditions /Behaviors:** | **(Attach additional information)**<br>☐ PASRR Level II-completed<br>☐Psychiatry Evaluation recommendation |
| ☐ **Diagnosis of Morbid Obesity**<br>(BMI 40 or higher and at least 100 pounds over ideal weight must include other d/x and need assistance with 1 ADL) | ☐**Bed**<br>☐**Lift Type**<br>☐**Wheelchair** | **(Attach charted measurements)**<br>Height_____**ft.** _____**in**<br>Weight_____**lb.** [or]_**kg**<br>Comorbidity: _____ |
| ☐ **Goal directed therapies**<br>Received therapist totaling 5 days per week for 2 of 3 disciplines. | ☐**PT**<br>☐**OT**<br>☐**ST**<br>**Frequency:** | **(Attach PT/OT/ST treatment plan/ goals/progress notes)** |
| ☐ **Ventilator Dependent**<br>(life sustaining for 6 or more hours a day) | **Name & List settings** | **(Attach ventilator orders/settings)** |
| ☐ **Dialysis** | **Frequency** | **(Attach Dialysis schedule)** |
| ☐ **HIV** (CD4 level equal to or less than 500) | **Taking 2 or more medications for HIV treatment** | **(Attach medication list for HIV treatment)** |

Applicant Name _____

**ADL SELF-PERFORMANCE-- (Code for client's PERFORMANCE during last 7 days--Not including setup)**

1. **INDEPENDENT** - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
2. **SUPERVISION** - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

**LIMITED ASSISTANCE** - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days

3. **EXTENSIVE ASSISTANCE** - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time:
   --Weight-bearing support
   --Full caregiver performance during part (but not all) of last 7 days
4. **TOTAL DEPENDENCE** - Full caregiver performance of activity during entire 7 days

**DEFINITIONS**

A. **TRANSFER** - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)
B. **LOCOMOTION** - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair.
C. **DRESSING** - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.
D. **EATING** - How the client eats and drinks (regardless of skill).
E. **TOILET USE** - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

| | Code Here |
|---|---|
| **TRANSFER** | |
| **LOCOMOTION** | |
| **DRESSING** | |
| **EATING** | |
| **TOILET USE** | |

**BATHING**--How client takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)

0. Independent--No help provided
1. Supervision--Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

| | Code Here |
|---|---|
| **BATHING** | |

**CONTINENCE SELF-CONTROL CATEGORIES (Code for client performance over 14 days)**

0. CONTINENT - Complete control
1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT - BLADDER, tends to be incontinent daily, but some control present; BOWEL, 2-3 times a week
4. INCONTINENT - Has inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel

| | | Code Here |
|---|---|---|
| **BOWEL CONTINENCE** | ***Control of bowel movement, with appliance or bowel continence programs, if employed.*** | |
| **BLADDER CONTINENCE** | ***Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants)*** With appliances (e.g., Foley) or continence programs, if employed | |

**TO BE COMPLETED BY SCDHHS REPRESENTATIVE**

☐ Approved Effective Date From_____To_____

☐ Denied Reason(s) _____

SCDHHS Representative_____Date: _____

# SOCIAL HISTORY FOR MI LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____

2. Ability to Communicate: _____

3. Mental Status: _____

4. Observed Behavior: _____

_____

5. Current Living Situation: _____

_____

6. Significant Family History: _____

_____

7. Social/Personal and Support Systems: _____

_____

_____

8. Maladaptive/Inappropriate Behavior: _____

_____

_____

9. Past Mental Health History: _____

_____

_____

10. Medical History & Impact of Medical Problems on Individual's Functioning: _____

_____

_____

11. Present Treatment: _____

_____

12. Summary/Comments: _____

_____

_____

Signature: _____ Date:

DHHS Form 247 (7/92)

**User's Guide for Social History for MI Level II PASARR Screening**

The intent of the Social History is to obtain further information which relates to the MI indicators and is not normally included on the 1718 and Level I screening.

2) Comment on all forms of communication, i.e. verbal, sign language, etc.

3) Comment on Mental Status - Such as alert, oriented, attention span, memory, awareness, thought process, etc.

4) Comment on Observed Behavior: Such as facial expression, eye contact, repetitive behavior, etc.

5) Comment on family composition, home environment, etc.

7) Comment on the ability to form and maintain relationships, interact with the community, positive-negative interactions, etc.

8) Comment further on behavioral indicators.

9) Include hospitalization treatment, out-patient treatment, compliance to treatment, etc.

11) Comment on present mental health treatment.

12) Include informants, reliability of information, and a brief evaluation of client.

# SOCIAL HISTORY FOR ID LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____
2. Ability to Communicate: _____
3. Mental Status: _____
4. Observed Behavior: _____
5. Birth and Early Development History: _____
6. Social Development: _____
7. Social/Personal Significant Family History: _____
8. Independent Living Development/Ability: _____
9. Maladaptive/Inappropriate Behavior: _____
10. Medical History: _____
11. Impact of Medical Problems on Individual's Functioning: _____
12. Community Social Supports: _____
13. Summary/Comments: _____

Signature: _____ Date:

DHHS Form 248 (4/17)

## User's Guide for Social History for ID Level II PASARR Screening

The intent of the Social History is to obtain further information which relates to the ID indicators and is not normally included on the 1718 and Level I screening.

2. Comment on all forms of communication, i.e. verbal, sign language, etc.

3. Comment on mental status such as alert, oriented, attention span, memory, awareness, thought process, etc.

4. Comment on observed behavior such as facial expression, eye contact, repetitive behavior, etc.

5. Comment on developmental milestones, speech and language development, cognitive development, significant education, and/or vocational history, etc.

6. Comment on relationships with others, interpersonal skills, social functioning, recreational and/or leisure activities.

8. Comment on independent living skills such as financial management, survival skills, ability to make decisions, etc.

9. Comment further on behavioral indicators.

10. Comment on such conditions as seizures, other neurological abnormalities, etc.

12. Comment on past or present association with DDSN and/or community/social supports.

13. Include informants, reliability of information, a brief evaluation of client and legal status, if pertinent.

**PASARR REFERRAL PACKET COVER LETTER**

Date:

To: _____ From:
_____

_____

RE:

Dear: _____:

The above named client has been reviewed through Community Long Term Care for possible nursing home placement.

Information received from the Level I screening indicates that this client may have _____. Therefore, as required by federal guidelines, we are referring this client to you for further evaluation and determination. Enclosed are the forms checked below.

We appreciate your assistance and look forward to receiving your report as soon as possible. If you have any questions, please feel free to call me at _____.

Sincerely,

Enclosures:
____ Level I Screen - Mini Mental State Exam Psychiatric Evaluation
____ Client Consent Form
____ SC Long Term Care Assessment Form (1718)
____ Social History
____ Physician's History and Physical
____ Copies of Hospital/Nursing Home Records
____ Other

May 15, 2007

DHHS Form 249

| NAME: | SSN: | DATE: |
|---|---|---|

## I. PSYCHIATRIC HISTORY

A. Hospitalizations

1. Has the patient had a history of hospitalizations for psychiatric illnesses? Yes ____ No ____ Unknown ____
2. Number of hospitalizations: _____
3. Date and duration of most recent psychiatric hospitalization: Date: ____/____/____ Total number of days hospitalized: _____
4. Major symptoms and/or diagnosis: (Report as described or stated in medical records)

_____

B. Outpatient History

1. Has the patient ever been in outpatient treatment for one year or longer? Yes ____ No ____ Unknown ____
2. Which of the following services did the patient receive?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ | Counseling | _____ | Day Treatment | _____ | Short-term Outpatient | _____ | Crisis Intervention |
| _____ | Medication | _____ | Residential Treatment | _____ | Local Inpatient | _____ | Case Management |

3. Major symptoms and/or diagnosis. Report as described or stated in the medical records.

_____

## II. PSYCHIATRIC CONDITION

A. Affect. Affect is the emotion that people express when interacting with others and their environment. A normal affect is when people laugh or show sadness or pleasure or grief in a manner consistent with the topic being discussed or the event being observed. A flat affect is to express little or no affect at all; a labile affect changes frequently and is often inconsistent with the subject being discussed or the event. A euphoric affect is exceptionally high with no obvious basis for it. Affect is changeable, whereas mood is a constant or fundamental emotion underlying all interactions.

Y = Yes N = No U = Unspecified or Unknown

| | | | | | |
|---|---|---|---|---|---|
| Normal | Y N U | Angry | Y N U | Other (Describe)_____ | |
| Flat or blunt | Y N U | Labile or changeable | Y N U | _____ | |
| Sad or blue | Y N U | Euphoric or elated | Y N U | _____ | |

B. Mood. Mood is the constant or fundamental emotion. For example, a depressed person may laugh but there is a sad or cynical quality to it. Facial expression and body language may continue to reflect a despondency. An anxious mood might be expressed as nervousness or lack of confidence in responses given. Fearfulness might be expressed as concern that responses will elicit negative consequences. Elation might be expressed as feeling "on top of the world" when circumstances should leave the person feeling otherwise. A normal mood is one that is consistent with the person's circumstances and denotes appropriate acceptance of circumstances with constructive adaptability.

| | | | | | |
|---|---|---|---|---|---|
| Depressed | Y N U | Anxious | Y N U | Other (Describe)_____ | |
| Elated | Y N U | Normal | Y N U | _____ | |
| Fearful | Y N U | | | _____ | |

C. Thinking Patterns. Thinking patterns are reflected in the patient's capacity to respond to questions and engage in conversation. If patterns are incoherent or confused, the response is illogical or unrelated. If patterns are loose or tangential that questions or conversational points result in the patient referencing something that is not connected or pertinent to the content of the conversation, then perseverance or obsessiveness is reflected by constant repetition of a point, observation or constant repetition of a point, observation or concern, and an inability to move to other topics.

| | | |
|---|---|---|
| Incoherent or confused | Y N U | Other (Describe)_____ |
| Loose or tangential | Y N U | _____ |
| Persevering or obsessive | Y N U | _____ |

NAME:

D. Sensorium and Thought Disorders. These are disorders common to various psychoses.

1. Auditory Hallucinations: Commonly thought of as "hearing voices". Y N U
2. Visual Hallucinations: Seeing things and/or people that are not there. Y N U
3. Delusions: A false personal belief based on incorrect inference. Y N U
   a. Persecutory: The feeling that people are out to harm one. Y N U
   b. Grandiose: An exaggerated sense of Importance or power. Y N U
4. Hypochondriacal: A preoccupation with the fear or belief of having a disease. Y N U
5. Obsessive or ritualistic: Recurrent, persistent thoughts/actions that are not experienced as voluntary; perceived as compelling. Y N U
6. Phobias: An irrational fear of a specific object, activity or situation. Y N U
7. Acted on content. Has the patient ever acted in response to or as a result of a delusion or hallucination? Y N U
   Describe the action or behavior:
   _____
   _____

E. Suicidal/Homicidal Potential. Direct questioning is often the best approach to evaluating suicidal/homicidal potential.

1. Expresses ideas of suicide or homicide. Example: Have you ever had thoughts of hurting yourself? Have you thought of how you would do it? Y N U
2. Has made plans for suicide/homicide. Example: Have you ever tried to hurt yourself? What did you do? Y N U
3. Has made suicidal/homicidal gestures or attempts. Example: Have you ever felt so angry you wanted to hurt someone, or attempted to? Y N U

F. Object Relationship to Others. This is the patient's capacity to relate to others and problems in relating to others.

1. Cooperative: An ease and confidence; give and take eye contact and animation. Y N U
2. Paranoid: Guarded, suspicious, untrusting attributes; negative intent to questions and actions of others. Y N U
3. Withdrawn: Little/no eye contact, pulling/turning away, asks to be left alone, volunteers little. Y N U
4. **Resistive: Withholding of information, answers brief and literal; gives little. Y N U**
5. Fearful: Anxious about purpose or intent; Physically holding self or pulls away; worries, frets. Y N U
6. Hostile: Belligerent, angry, refuses to answer or deliberately misleads or misinforms; uncooperative. Y N U
7. Other (Describe):_____
   _____

G. Speech.

1. Pressured: Speech that is difficult to interrupt because of its speed, amount, or accelerated pace. Y N U
2. Blocked: Interrupted speech before a thought or idea has been fully expressed. Y N U
3. Rapid: A nearly continuous flow of speech of an extremely accelerated pace. Y N U
4. Echolalic: Patient repeats the words/phrases of others-not to be confused with efforts to clarify questions. Y N U
5. Slow: Long pauses between words; may appear that patient has to give much thought to each word. Y N U
6. Nonsensical: Speech may consist of words or sounds but they have no clear relationship to a thought or idea. Y N U
7. Normal: Speech consists of words that are organized to communicate coherent thoughts and ideas. Y N U

H. Behavior.

1. Agitated or hyperactive: Very mobile, pacing, fidgety, always busy. Y N U
2. Combative: Strikes others without provocation; unpredictable, aggressive, acting out behavior. Y N U
3. Repetitive purposeless activity: Repeats the same behavior over and over with no clear purpose. Y N U
4. Abnormal, involuntary movements: Parts of the body appear to jerk or twitch. Y N U
5. Rigid body and/or extremities: Patient's body appears rigid; patient does not move voluntarily; wooden. Y N U
6. Slow or lack of body movements: Patient moves voluntarily but extremely slow. Y N U
7. Motor restlessness: Restless feeling from within; will rub arms/legs; moves legs up and down; cannot relax. Y N U
8. Gait abnormality: Writhing, dancing or shuffling motion to gait. Y N U
9. Other Describe):_____
   _____

| **CLIENT NAME:** | **SSN:** |
|---|---|

III. INDEPENDENT EVALUATION REPORT AND RECOMMENDATION

The above named client has been identified as having medical needs sufficient to require nursing facility care. The individual is also suspected of having a mental illness. A review of the individual's current physical, mental and functional status, psychosocial history, psychiatric history and drug history was conducted. After prioritizing the physical and mental needs of this individual, my findings are as follows:

____ 1. The individual exhibits no evidence of a mental illness which would require any mental health services above those required to be provided by a Medicare/Medicaid certified nursing facility.

____ 2. The individual has a mental illness that is stable or in remission under his/her current treatment regime.

____ 3. The individual has a mental illness for which he/she is in need of psychiatric/mental health treatment services, as indicated in the recommendations indicated below. These needs can be appropriately met in a Department of Mental Health facility or a nursing facility.

____ 4. The individual has a serious acute mental illness and is in need of specialized services by psychiatric professionals.

DIAGNOSIS:_____

_____

_____

Summary of individual's pertinent history and current status, including positive traits or developmental strengths and weaknesses or developmental needs per requirements of §483.128(g):

Specific psychiatric/mental health services recommended to meet the individual's needs:

Basis for these conclusions:

| Physician Signature: | Date: |
|---|---|

SOUTH CAROLINA COMMUNITY LONG TERM CARE

**LEVEL OF CARE CERTIFICATION LETTER**

FOR

MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

South Carolina Community Long Term Care has evaluated your application and has determined that:

- ☐ According to Medicaid criteria, you do not meet medical requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long-term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.
- ☐ According to Medicaid criteria, you meet the medical requirements to receive long-term care at the following level:

  ☐ SKILLED ☐ INTERMEDIATE

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long-term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.

Telephone No.

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

- ☐ **If the location of care is a hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG-TERM CARE FACILITY.**

FOR LONG-TERM CARE FACILITY USE

- ☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)
- ☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date:_____

Nurse Consultant Signature:_____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

## APPEALS

As a Medicaid nursing home or home and community-based waiver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification:

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received, pending the decision, to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time, and place the hearing will take place.

In your request for a fair hearing you must state with specificity what issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth ($30^{th}$) calendar day following receipt of this notification.

**SOUTH CAROLINA COMMUNITY LONG TERM CARE**

**CONSENT FORM**

Client Name: _____

Social Security Number: _____

I understand as part of my application for long term care services in the community or a Title XIX nursing home, my condition must be evaluated by the South Carolina Community Long Term Care Program.

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals and organizations involved with my care; and,
c. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses, or other medical personnel or medical facilities involved in my care to release to Community Long Term Care any medical information regarding my diagnoses and recommended treatment.

I hereby authorize Community Long Term Care to release information on my behalf to physicians, hospitals, health and human service organizations, health and human service agencies, family members and/or other persons directly involved with my care.

I understand if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the statewide Alzheimer's Disease and Related Disorders Registry, and I, or my responsible party, may be contacted for additional information.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information.

_____

_____

_____

This consent shall remain in effect until _____, revoked by me in writing, or until such time as my case is closed by Community Long Term Care.

*Date:* _____ _____
*Signature of Client or Responsible Party*

_____
*If Signed by Responsible Party, State Relationship and Authority to Sign.*

*Date:* _____ _____
*Signature of Witness*

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**PASARR - Level I SCREENING FORM**

| | |
|---|---|
| Name: | Date of Review: |
| SSN: | Location at assessment: |
| Medicaid: Non-Medicaid: | CLTC#: |
| Date of birth: | Referral source: |
| All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form): | |
| | |
| | |

**I. SCREENING FOR INTELLECTUAL DISABILITIES INDICATORS:**

| | YES | NO |
|---|---|---|
| 1. Diagnosis of intellectual disabilities or related disabilities made prior to age 22? | | |
| 2. IQ tested below 70? | | |
| 3. Was time of test prior to age 22? | | |
| 4. Does client have 3rd grade education? If not, state reason in Comments Section. | | |
| 5. Adaptive behavior: Could client ever perform self care activities? | | |
| - Did he/she help care for spouse/parents/children? | | |
| - Was client ever able to cook and perform household duties? | | |
| - Was client gainfully employed? If not, explain in Comments Section. | | |
| - Did client have driver's license? | | |
| 6. Cognitive Functioning: | | |
| - Memory: Does client remember what he/she had for breakfast or lunch? | | |
| - Simple math: Can client add 12 + 8? | | |
| - Concept formation: Can client describe the difference between a fish and dog? | | |

7. Comments: _____

_____

**II. SCREENING FOR MENTAL ILLNESS INDICATORS:**

1. Diagnosis of mental illness: No ___ Yes ___ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. (Give dates of treatment) If no hospitalization, indicate here: _____

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ ___/___/___ to ___/___/

3. Current behavioral indicators:

| | | | |
|---|---|---|---|
| Attempted suicide | ___ | Unrealistic fear of strangers | |
| Assaultive | ___ | Self-mutilation | |
| Incessant loud talking | ___ | Combative | |
| Uncooperative | ___ | Social isolation | |
| Hostile | ___ | Destruction of property | |
| | | **None of these indicators:** | |

4. Comments: (Include explanation of major symptoms): _____

_____

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**PASARR - Level I SCREENING FORM**

NAME: _____ **SSN**: _____

**III. LIST ALL PSYCHOTROPHIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.**

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

**IV. RECOMMENDATION OF REVIEWER:**

____ Recommend further evaluation based on intellectual disabilities indicators.
____ Recommend further evaluation based on mental illness indicators.
____ No further evaluation recommended.
____ No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)

**V. PERTINENT INFORMATION**

____ IMD admission requested; if so, indicate facility: _____
____ Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: _____ CLTC Area # _____

Signature and title of assessor: _____

Agency/Institution completing form: _____

Admitting Nursing Facility: _____ Date of Admission (if known) _____

**FOR CLTC/IOC USE ONLY**

FOR CLTC USE ONLY
Reviewed by Nurse Consultant _____ (initials)
Date Reviewed: _____

**VI. ADVANCE CATEGORICAL DETERMINATION**

____ Advance categorical determination that specialized services are not required:

____ 1. Severity of physical impairments overrides need for specialized services (MI only)
____ 2. Nursing facility respite not to exceed 14 days (ID or MI)
____ 3. Emergency admission due to suspected abuse/neglect under authority of DSS (ID or MI)
____ 4. 30-Day time limited certification (ID or MI)
____ 5. Intellectual disability with concurrent diagnosis of dementia (ID only)

Signature of CLTC Nurse Consultant:

Date sent to nursing facility: Initials:

# South Carolina
# Department of Health and Human Services

**Resident Case Mix Classification Change**

**Facility Name** _____

**Resident Name**_____ **Social Security #**_____

**Resident Medicaid #**_____ **Attending Physician**_____

Your case has been reviewed by the Interdisciplinary Team to determine if it is medically necessary for you to continue to receive nursing facility care.

1. According to current Medicaid criteria, it has been determined that your classification has been changed to:

   - ❑ Skilled Care
   - ❑ Intermediate Care

The above classification change has no impact on your continued stay in the nursing facility.

2. According to current Medicaid criteria, it has been determined that:

   - ❑ You no longer need nursing facility, ICF/IID, or psychiatric IMD care. This does not mean that you do not need personal or other care, and does not mean that you cannot continue to receive skilled, intermediate (Including ICF/IID), or psychiatric IMD care. It does mean that the Medicaid program will not continue to pay for such care. The county Department of Health and Human Services will notify you of the proposed date for termination of your benefits.

If you disagree with this determination, please read the reverse side of this notification.

**Signature** _____ **Effective Date** _____

Cc: Recipient
Responsible Party
Administrator of Facility
County DHHS Office
*SCDHHS Division of Community and Facility Services

*(Less Than Intermediate Only)

# APPEALS

AS A MEDICAID PATIENT, YOU HAVE A RIGHT TO A HEARING REGARDING THIS DECISION.

1) YOU HAVE A RIGHT TO APPEAL WITHIN SIXTY (60) DAYS;
2) IF YOU APPEAL WITHIN TEN (10) DAYS YOUR MEDICAID BENEFITS WILL CONTINUE UNTIL A DECISION IS MADE BY THE HEARING PANEL;
3) IF THE HEARING PANEL DOES NOT DECIDE IN YOUR FAVOR, ACTION WILL BE INITIATED TO RECOUP MEDICAID PAYMENTS MADE IN EXCESS OF 30 DAYS BEYOND THE INITIAL ADVERSE DECISION. YOU MUST REPAY THE MEDICAID PROGRAM FOR PAYMENTS DURING THE TIME YOU WERE INELIGIBLE;
4) IF YOU DO NOT WANT YOUR BENEFITS TO CONTINUE WHILE THE HEARING PANEL IS DECIDING ON YOUR CASE, YOU MUST REQUEST IN WRITING THAT YOUR BENEFITS BE STOPPED.

ALL APPEAL REQUESTS SHOULD BE SUBMITTED TO:

APPEALS AND HEARINGS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
POST OFFICE BOX 8206
COLUMBIA, SC 29202

YOU OR YOUR REPRESENTATIVE WILL BE NOTIFIED OF THE DATE, TIME AND PLACE THE HEARING WILL TAKE PLACE.

**South Carolina Department of Health and Human Services**

# REQUEST FOR ASSESSMENT OF LEVEL OF CARE

From: _____ DHHS

_____

_____

To: _____

_____

_____

---

The individual named below has applied for Medicaid. Please complete an assessment immediately and forward it to Community Long Term Care (CLTC) or the Department of Disabilities and Special Needs (DDSN) for a determination of level of care.

| **Applicant** | | |
|---|---|---|
| Name of Applicant: | | Date of Birth: |
| Home Address: | | Telephone Number: |
| Social Security Number: | Date of Medicaid Application: | Category of Application: |
| Directions to Home: | | |

| **Authorized Representative** | |
|---|---|
| Name of Authorized Representative: | Relationship to Applicant: |
| Home Address: | |
| Home Telephone Number: | Work Telephone Number: |

Medicaid Worker's Signature: _____ Date: _____

# SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
# SOUTH CAROLINA PAID FEEDING ASSISTANTS CORE CURRICULUM

## A. Basic Infection Control Practices - 1 hour

1. Describe basic infection control principles and proper handwashing techniques during meal service and feeding of a resident.
2. Demonstrate proper handwashing technique.

## B. Respecting Resident's Rights - 1 hour

1. Describe the Resident's Bill of Rights.
2. Describe a minimum of two examples of promoting resident's rights during mealtime while feeding or assisting to feed a resident.
3. Define resident's rights to protection and confidentiality.

## C. Communication and Interpersonal Skills - 1 hour

1. Describe and demonstrate appropriate social interaction and communication during feeding.
2. Describe several types of communication techniques as well as barriers to communication.
3. Describe the importance of effective communication.
4. Identify and describe appropriate responses to resident behavior, i.e. dementia resident.

## D. Safety and Emergency Procedures - 1 hour

1. Describe signs and symptoms of choking.
2. Demonstrate management of obstructed airway (Heimlech Maneuver).
3. Describe the facility's emergency response plan, i.e., call system.

## E. Feeding Techniques, Assistance with Feeding and Hydration - 3 hours

1. Demonstrate the knowledge that a feeding assistant feeds only residents who have no complicated feeding problems, including, but not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
2. Describe feeding techniques and hydration measures.
3. Demonstration of selecting proper diet and meal intended for a particular resident.
4. Demonstrate proper techniques in feeding and assisting to feed resident.
5. Describe and demonstrate facility procedure for computing resident intake during mealtime.

## F. Principles of Observation and Reporting - 1 hour

1. Describe how to observe a resident for changes inconsistent with their normal behavior.
2. Describe how to report what is observed to the supervisory nurse.

# Requirements of Paid Feeding Assistant Program

1. Feeding Assistant Program must be a minimum of eight (8) hours.
2. Feeding Assistant Program must be **State Approved**.
3. Each nursing facility must maintain a record of all individuals used as feeding assistants, who have successfully completed the training course for paid feeding assistants. The nursing facility must also have on file evidence that the individual has successfully completed a state approved program with the necessary competency to feed a resident.
4. Feeding Assistant Program must be coordinated, performed by and under the general supervision of a registered nurse or licensed practical nurse.
5. Feeding assistants must work under the supervision of a registered nurse (RN) or a licensed practical nurse (LPN) who is readily available.
6. A nursing facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
7. The nursing facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

# State Approval Guidelines for Paid Feeding Assistant Programs

**1.** State approval is initiated by obtaining or requesting the South Carolina Core Curriculum for Paid Feeding Assistants, Requirements, and Guidelines from the Department of Health and Human Services' (DHHS) website at: **www.dhhs.state.sc.us** or by mail or fax. The below agreement must be read, signed, and maintained on record by the administrator/program coordinator of the feeding assistant program and the DHHS, Department of Facility Services representative. **This agreement shall remain in effect as long as the facility has a feeding assistant program.**

By signature of the authorized individual below, _____ (please insert the name of your facility/program) agrees to follow the South Carolina Feeding Assistant Core Curriculum and requirements. _____(please insert the name of your facility/program) understands and agrees that DHHS reserves the right to conduct announced or unannounced evaluations of our feeding assistant program at anytime.

_____ _____

**Administrator/Coordinator Signature** **Date**

_____ _____

**Signature of DHHS Representative Acknowledging Receipt of Agreement** **Date**