Application for Case Management:

The Community Long Term Care (CLTC) Program contracts with qualified providers to provide Case Management services to Medicaid recipients. The service is prior authorized by CLTC State case managers. The authorization includes the necessary information for service provision and allows for Care Call billing. Contracting as a provider of Case Management the provider agrees to serve the following groups:

- South Carolina Community Choice Waiver Participants;
- HIV/AIDS Waiver Participants;

Monthly reimbursement rates are as indicated below:

- Community Choices Case Management: $50.35
- HIV/AIDS Case Management: $50.35

Providers must follow the Case Management Scopes of Services for this service, as well as meeting all other contractual obligations. The Scope of Services can be found on this web site. You should print a copy to review before completing this application.

Each participant is required to choose a provider from a CLIENT CHOICE OF PROVIDER FORM that lists all CLTC providers by county. Because of the client choice of provider policy we cannot guarantee the number of CLTC clients any provider will be authorized to serve. Therefore, we urge all providers not to rely upon Medicaid as the primary source for reimbursement. **Business decisions should not be made based on any agency's or individual's anticipation of receiving any referrals from CLTC**.

In order to complete an application, print this document. Check the appropriate boxes and provide the information that is requested.

Applications should be sent to: **Division of Community Long Term Care- Waiver Management, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Ann Coker**. If you have any questions regarding this process or the stated requirements, please call Ann Coker at (803) 898-82722.

Once your application has been completed and processed, CLTC will schedule a pre-contractual review with you or your agency.

The following items must be checked and/or enclosed for this application to be considered for processing:

I wish to become a provider of the following services: (Check all for which you are applying)

❑ Independent Case Manager

❑ Agency Case Management Company

❑ I understand that all case management services must be delivered by a Licensed Social Worker, Licensed Professional Counselor, Licensed RN or by a BSW, MSW with two years of experience in a health or social services field.

❑ I understand that case managers must have an extensive knowledge of and ability to utilize computer hardware and computer software.

❑ I understand that It will be necessary to schedule a DHHS pre-contractual review as part of the contracting process and that I will be contacted to schedule this visit.

❑ I agree to abide by all requirements and policies of the Department of Health and Human Services as will be described in my contract and any other communication received from DHHS.

❑ I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the CLTC Program within the last three (3) years, or previously worked in CLTC and did not leave in good standing.

❑ By checking this box I am indicating that my agency requires Medicaid participants to sign agreements. (Leave blank if this is not the case.) I understand that I must include copies of all agreements with this provider application.

❑ If an agency, I certify that this agency has written bylaws or the equivalent, which is a set of rules adopted by the provider agency for governing the agency's operations.

❑ I certify that this agency/individual will submit any subcontracts to DHHS for prior approval.

❑ If an agency, I certify that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

❑ My regularly scheduled holidays are listed on the attached sheet.

❑ The county or counties in which I/my agency plans to provide services are listed on the attached sheet:

❑ If agency, I understand that this agency may be reviewed by DHHS at any time during normal business hours. This review can be announced or unannounced. I also understand that my agency must produce all requested records related to the administration of the agency, and staff records.

❑ I understand that persons providing in-home services must use the Care Call system to document their service delivery and adherence to this contract.

❑ I understand that in order to provide case management services there can be no connection to the service delivery system.

❑ I understand that I must abide by all marketing limitations as indicated in the contract.

❑ I understand that I must not give any type of gifts, samples or other products to CLTC employees.

❑ I understand that I/my staff must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.).

The name of the person who will sign the contract: _____

The name of the person designated to serve as the agency administrator:

_____

The following items must be submitted with your application:

- If agency, you must submit <u>certified evidence of operating capital</u> that will show that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant.

- Documentation that demonstrates licensure or experience, i.e., and written references, etc., for providing case management services.

- If agency, a copy of your organizational chart that includes the names of persons in any management or ownership capacity. (See attached form)

- If agency, a copy of the provider agency's Workers' Compensation Insurance Policy. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to contract processing.

- A copy or letter of certification of the individual or agency provider's current Professional Liability Insurance Policy showing coverage to include date of application.

- If an agency is incorporated, a copy of your articles of incorporation or other document that established you as a legal entity. If you do not already have this, it must be obtained from the Secretary of State.

- A completed Pre-contractual Information Form. (See attached form)

- The Provider must disclose to SCDHHS the names and relationships of any relatives of the Provider or its staff who provide items or services to Medicaid beneficiaries.

I certify that all information given with this application is true. I understand that any false information will result in this application being denied.

_____	_____	_____
Applicant's signature	**Title**	**Date**

Address:

_____

_____

_____

Mailing address if different than above:

_____

_____

_____

Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

List of Scheduled Holidays

Check each holiday observed by your agency and indicate additional holidays below.

- ❑ New Year's Day
- ❑ Martin Luther King's Birthday
- ❑ Presidents Day
- ❑ Good Friday
- ❑ Easter
- ❑ Memorial Day
- ❑ Fourth of July
- ❑ Labor Day
- ❑ Veterans Day
- ❑ Thanksgiving
- ❑ Day after Thanksgiving
- ❑ Christmas Eve
- ❑ Christmas
- ❑ Day after Christmas

List additional holidays here:

_____

_____

Counties Served

Put a check next to every county in which you intend to provide services. Counties served can be updated at anytime.

- [ ] Abbeville
- [ ] Aiken
- [ ] Allendale
- [ ] Anderson
- [ ] Bamberg
- [ ] Barnwell
- [ ] Beaufort
- [ ] Berkeley
- [ ] Calhoun
- [ ] Charleston
- [ ] Cherokee
- [ ] Chester
- [ ] Chesterfield
- [ ] Clarendon
- [ ] Colleton
- [ ] Darlington
- [ ] Dillon
- [ ] Dorchester
- [ ] Edgefield
- [ ] Fairfield
- [ ] Florence
- [ ] Georgetown
- [ ] Greenville
- [ ] Greenwood
- [ ] Hampton
- [ ] Horry
- [ ] Jasper
- [ ] Kershaw
- [ ] Lancaster
- [ ] Laurens
- [ ] Lee
- [ ] Lexington
- [ ] McCormick
- [ ] Marion
- [ ] Marlboro
- [ ] Newberry
- [ ] Oconee
- [ ] Orangeburg
- [ ] Pickens
- [ ] Richland
- [ ] Saluda
- [ ] Spartanburg
- [ ] Sumter
- [ ] Union
- [ ] Williamsburg
- [ ] York
- [ ] Statewide

Pre-Contractual Information Form

Have you ever worked for an agency that has received Medicaid funds? _____

If yes, what agency and what was your position? _____

_____

Have you have ever been an enrolled or contracted Medicaid provider?
If yes, when (dates)_____ Which state? _____ What service did you provide?_____

What was/is your previous/current Medicaid provider number? _____

Are you currently enrolled or contracted with DHHS for any service provision?

If not, when did contract or enrollment end?_____

If terminated, was termination voluntary or involuntary?_____

If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid? If yes, when? (dates)_____ Which state?_____

What type of service was provided?_____

What was/is the agency's or corporate entity's previous/current Medicaid provider number?_____

Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS?
_____

If yes, when? (dates) _____ For what service?
_____ Reason?
_____

Any falsification of information submitted is grounds for denial or termination of a contract.

_____ _____
Signature Date

SAMPLE ORGANIZATIONAL CHART

President

Name:_____

Chief Executive Officer

Name:_____

Chief Financial Officer

Name:_____

Chief Operations Officer

Name:_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

*This chart is only a sample and may not apply to the organizational structure of your company. You may utilize this chart or create your own that more closely represents the organizational structure of your company.