FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	06/2007
	Authorization Agreement for Electronic Funds Transfer	01/2009
CMS-1500	Sample Claim Showing TPL Denial with NPI	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice	06/2007
DHHS 254	Referral Form/Authorization for Services-Children's Behavioral Health Services	09/2009
	Medical Necessity Statement for Children's Behavioral Health Services	
	Medical Necessity Statement for Therapeutic Behavioral Services	
	Referral Request for Out-of-State Therapeutic Treatment Services	
DHHS 560	Therapeutic Behavioral Services Assessment (two pages)	08/2005
DHHS 561	Therapeutic Behavioral Services Weekly Progress Summary Notes	02/2005
DHHS 562	Therapeutic Behavioral Services Individual Treatment Plan-Attachment G	02/2005
	Consumer Satisfaction Survey	
	Sex Offender Protocol Endorsement Sheet	
	Critical Incident Report	
	Financial and Statistical Report	

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 - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE: NPI or MEDICAID PROVIDER ID: TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, etc.) DATE CLAIM FILED:

----------FOLD HERE----------

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) ☐ YES ☐ NO	IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ NO	
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17-DIGIT CLAIM REFERENCE NUMBER
STATEMENT OF PROBLEM OR QUESTION		
	SIGNATURE OF PROVIDER	
RESPONSE		
	AGENCY REPRESENTATIVE	DATE

SCDHHS Form 140 (revised 06/07)

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

WHEN COMPLETED PLEASE FORWARD TO:	NPI or MEDICAID PROVIDER ID:
SC DEPARTMENT OF HEALTH AND HUMAN SERVICES SUPPLY POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TYPE OF PROVIDER:
-OR- **FAX TO: (803) 898-4528**	TELEPHONE: - -
	CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY ***(PLEASE PRINT OR TYPE)***

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

SCDHHS FORM 142 (revised 06/07)

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

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	**or**	**Mail:**
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ DOS _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 05/2007

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

PROVIDER INFORMATION

Provider Name _____

Medicaid Provider Number _____

Provider NPI Number _____

Provider Address _____

City _____ State _____ Zip _____

BANKING INFORMATION (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

Financial Institution Name _____

Financial Institution Address _____

City _____ State _____ Zip _____

Routing Number (nine digit) _____

Account Number _____

Type of Account (check one) ☐ Checking ☐ Savings

I (we) hereby 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 my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee 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 (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ *(Signature)*

_____ *(Print)*

Title _____ Date _____

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.

RETURN COMPLETED FORM TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

EFT/Revised 01/09

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Children's Behavioral Health Services
Sample Claim Showing TPL Denial
with NPI

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☒ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☒ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John A.

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1999 | SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: SC

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐ | Employed ☒ Full-Time Student ☐ Part-Time Student ☐

CITY: | STATE:

ZIP CODE: 29999 | TELEPHONE (Include Area Code): ( )

ZIP CODE: | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: A1111111

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: 0.00

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: 401

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File | DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 295.32
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 31 07	01 31 07	99		H2019			102 00	12		ZZ	1212121212
														NPI	1234567890
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 555555555 | SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 102 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 102 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH # (555) 5555555

ABC Behavioral Health
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 | b. ZZ1212121212

RUN DATE 05/01/2007 000001204 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #9999999999999999A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 1136 ECF 1136 PAGE 1 OF 1
ANALYST ID HIC - 76 SPEC EMC Y
SIGNON ID DOC IND N ORIGINAL CCN:
TAXONOMY: SFL ZIP: PRV ZIP: ADJ CCN:

1 2 3 4 5 6 7 8 9 EDITS

PROV/XWALK RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ---- INSURANCE EDITS
ID ID NUMBER CODE PRIMARY SECONDARY
ABC123 1111111111 v71.02 . CLAIM EDITS
NPI: 1234567890

LINE EDITS
01) 712 951

10 RECIPIENT NAME – DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROVIDER	21 CHARGE IND	22 PAY	23 UNITS
	.00	1	02/01/00	99	H2020	0TF	900MXH	836.00	**	017

NDC

NPI: 1234567890 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 25 26
INS CARR NUMBER POLICY NUMBER INS CARR PAID

01

02

03

27 TOTAL CHARGE 836.00
28 AMT REC'D INS .00
29 BALANCE DUE 836.00
30 OWN REF # 012345

RESOLUTION DECISION _R_

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

PROVIDER:
ABC GROUP HOME
PO BOX 00000
ANYWHERE, SC 00000-0000

INSURANCE POLICY INFORMATION

AGENCY USE ONLY
APPROVED EDITS
REJECTED LINE EDITS

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! !
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Sample Remittance Advice (page 1)

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

AB0008 ABC GROUP HOME — PO BOX 000000 — FLORENCE — SC000000000

.121212121234. Y

PROVIDER ID. — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

AB00080000 — DEPT OF HEALTH AND HUMAN SERVICES — REMITTANCE ADVICE — 03/26/2007 — 1

SOUTH CAROLINA MEDICAID PROGRAM

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 F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021507	H2020	800.00	117.71	P			0TF			0.00
	02		021507	H0046	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0406001089000400U				1412.00-	273.71-		1112233333	M CLARK				
	01		012107	H2020	1112.00-	143.71-				0TF			
	02		012107	H0046	300.00-	130.00-				O00			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04												
ABB222222	0407701389002500A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		012107	H2020	142.50	42.75	P			0TF			0.00
	02		012107	H0046	859.00	0.00	R			000			0.00
	TOTALS		2		2193.50	286.46						0.00	0.00

$286.46

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
$0.00	0.00

FEDERAL RELIEF — MAXIMUS AMT — CHECK TOTAL — CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000-0000

Sample Remittance Advice (page 2)

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

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 03/26/2007

PAGE 2

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
ABB222222	00000000000000000U				513.00-	197.71-		1112233333	CLARK		M		022807	09999999999999999A
	01		012107	H2020	453.00	160.71-	P					0TF		
	02		012107	H0046	60.00	33.00-	P					O00		
	TOTALS		1		513.00-	193.71-								

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	$243.71	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
$193.71-	

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
0.00	$50.00	4197304

PROVIDER NAME AND ADDRESS

ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000-0000

Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 03/26/2007

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	04086000037000000U	-						DEBIT	-2389.05	
TPL 4	04086000047000000U	-						DEBIT	-1949.90	
TPL 5	04086000057000000U	-						DEBIT	-477.25	
TPL 6	04086000067000000U	-						DEBIT	-477.25	
							PAGE TOTAL:		5293.45	0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
0.00	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
5293.45	0.00	

PROVIDER NAME AND ADDRESS

ABC GROUP HOME
PO BOX 000000
FLORENCE SC 00000-0000

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REFERRAL FORM/AUTHORIZATION FOR SERVICES (Form 254)
CHILDREN'S BEHAVIORAL HEALTH SERVICES

FORM 254

NPI or Medicaid Provider ID

CHILD'S MEDICAID I. D. #

REFERRED TO: _____

_____

_____

AUTHORIZATION DATE: ___/___/___

EXPIRATION DATE: ___/___/___

Name	County	Address		
Date of Birth ___/___/___	Sex	Agency Reference No.	City	State Zip
Prior Authorization Number		Parent/Guardian		

Services are authorized for the period from the Authorization Date through the Expiration Date as noted above. The authorization period is subject to change pending notification by the Authorizing Agency or by the Department of Health and Human Services. This referral is valid only for the dates on which the client is eligible for Medicaid.

- ☐ PSYCHIATRIC HOSPITAL
- ☐ RESIDENTIAL TREATMENT FACILITY
- ☐ THERAPEUTIC FOSTER CARE
  - ☐ LEVEL I (S5145) ☐ LEVEL II (S5145-TF) ☐ LEVEL III (S5145-TG)
- ☐ MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED (Formerly Intensive Family Services) (H0046)
- ☐ PSYCHOSOCIAL REHABILITATION SERVICES (Formerly Clinical Day Programming) (H2018)
- ☐ THERAPEUTIC BEHAVIORAL SERVICES (Formerly Therapeutic Child Treatment) (H2019 & H2020-HA)
- ☐ OTHER _____

Agency Representative:_____ Title: _____

Signature: _____ Phone: _____

Authorizing Agency: (one must be checked)

- ☐ Department of Social Services
- ☐ Continuum of Care for Emotionally Disturbed Children
- ☐ United Way
- ☐ Department of Mental Health
- ☐ Department of Disabilities and Special Needs
- ☐ Department of Juvenile Justice
- ☐ School District/ Department of Education

AGENCY USE ONLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
CHILDREN'S BEHAVIORAL HEALTH SERVICES

Child's Name:_____ Social Security Number:_____

Date of Birth:_____ Medicaid Number:_____

Based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation, I recommend that the above-named Medicaid recipient receive _____

_____
(Specific Rehabilitative Service)

for maximum reduction of physical or mental disability and restoration of the recipient to his/her highest level of functioning. This recipient meets the medical necessity criteria for this level of care.

_____ _____
(Signature of Physician or other Licensed Practitioner of the Healing Arts) (Professional Title)

_____ _____
(Please print name signed above) (Phone Number)

Date of Signature: _____ (Services must be initiated within 90 days)

Diagnosis and Diagnosis Code: _____

In the absence of a full clinical assessment and evaluation, use of a V-Code may be appropriate. A more thorough diagnosis and the corresponding diagnosis code should replace the V-Code when available.

V61.20	Parent-child relational problem	V62.81	Interpersonal problems, not elsewhere classified
V61.21	Neglect/Abuse of Child	V62.82	Bereavement
V61.9	Relational Problem Related to a Mental Disorder	V71.02	Child or Adolescent Antisocial Behavior

Child's identified problems areas or needs. These may be based on professional staffing recommendations, review of treatment history and/or personal observation or evaluation.

_____

_____

_____

_____

_____

_____

S. C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL NECESSITY STATEMENT
FOR
THERAPEUTIC BEHAVIORAL SERVICES

Recipient's Name: _____

Recipient's Date of Birth: ____ / ____ / _____

Recipient's Social Security Number: ____ / ____ / _____

Recipient's Medicaid Number: _____

Diagnosis Code: _____ ICD-9 CM or Acceptable V-Code

I recommend that the above named Medicaid recipient receive Therapeutic Behavioral Services for maximum reduction of physical or mental disability and restoration of the recipient to his/her best possible functional level. The recipient meets the medical necessity criteria for this service as evidenced by

1. The attached developmental and emotional screening tool used. (Must be comparable to the Denver Developmental Screening Test II as used in Early and Periodic Screening Diagnosis and Treatment (EPSDT) screenings), and

2. Meeting one of the following criteria: (circle the appropriate criteria(s))

   2.1 The child is unable to attend regular child care due to substantiated developmental or behavioral problems,

   2.2 The child exhibits developmental or behavioral problems as a result of substantiated cases of abuse /neglect with behavior problems, or

   2.3 The child is in imminent danger of being removed from the home due to substantiated developmental or behavioral problems.

_____ _____
(Signature of Physician or Licensed Practitioner of the Healing Arts) (Professional Title)

Date of Signature: ___/___/_____ (Service must be initiated within 90 days)

South Carolina

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Post Office Box 8206
Columbia, South Carolina 29202-8206

REFERRAL REQUEST FOR OUT-OF-STATE THERAPEUTIC TREATMENT SERVICES

Child Placing State Agency:_____

Child's Name:_____ Medicaid #: _____

Facility Being Referred To:

Name: _____

Address: _____

_____

Telephone: _____

Date Approval Received From Children's Case Resolution System: _____
(Approval **must** be obtained from CCRS if placement is more than 50 miles from the SC borders)

Medicaid patients being referred out-of-state may be provided transportation, as well as the patient's escort, when necessary. Adequate advance travel notice as well as prior approval is mandatory in order to make the necessary travel arrangements. Travel arrangements can be made by calling the Transportation Department at (803) 898-2565.

Will the patient require transportation? YES_____ NO_____

Recommended mode of transportation: _____

Any special instructions or requirements for travel assistance: _____

Other resources utilized/considered: _____

_____

Justification for Services: Check one of the following:

____ I certify that residential services appropriate to meet the child's therapeutic needs are not available within the South Carolina service area, which includes North Carolina and Georgia within 25 miles of the border.

____ Although services are available within the South Carolina service area, the distance to the in-state facility would prevent the family and child placing state agency from being actively involved in the child's treatment regime.

_____ _____
Signature of Child Placing State Agency Date

Provider must be enrolled in the South Carolina Medicaid program for the Department of Health and Human Services to reimburse for services.

Therapeutic Behavioral Services
(formerly Therapeutic Child Treatment)
Assessment

Attachment H

Client: Birth Date: / /

DATES
Admission: / / Plan: / /

Participants	Initial Goals / Desired Outcomes	Strengths	Barriers
Primary Caregiver			
Secondary Caregiver			
Other Family			
TBS Child			
School / Day Care			
Neighborhood/Community			

Lead Clinical Staff (LCS) Signature Date

Supervising LCS Signature Date

Genogram	Presenting Problem and the Impacting Issues

Therapeutic Behavioral Services Assessment

Client:

DHHS Form 560 (09/2005 Version)

Lead Clinical Staff (LCS) Signature _____ Date _____

Supervising LCS Signature Date

Therapeutic Behavioral Services

(formerly Therapeutic Child Treatment)

WEEKLY PROGRESS SUMMARY NOTES

Client:
Birth Date: / /

	Mon	Tue	Wed	Thu	Fri
Date					
Number of Units					

Page 1 Attachment DHHS Form 561

Short Term Goals addressed this week (These should complement the Overarching and Short Term Goals listed in the child's ITP)	**Intervention(s) used to address Short Term Goals**	**Barriers to Short Term Goals**	**Advancement in Treatment**	**Changes in Assessment**	**Short Term Goals for Next Week**

Non-LCS Signature (When Required) _____ Date _____
Lead Clinical Staff (LCS) Signature_____ Date _____
Supervising LCS Signature:_____Date _____

Therapeutic Behavioral Services
(formerly Therapeutic Child Treatment)
INDIVIDUAL TREATMENT PLAN
Attachment G

Client: Birth Date: / /

DATES
Admission: / / Plan: / /
1st Review: / / 2nd Review: / /
3rd Review: / / Re-Development: / /

Reasons for Referral / Presenting Problems:

Overarching Goals	Criteria for Achievement	Target Date	Completion Date
1		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /
4.		/ /	/ /

Primary Caregiver Signature _____ Date _____ Lead Clinical Staff (LCS) Signature _____ Date _____

Other Caregiver Signature _____ Date _____ Supervising LCS Signature _____ Date _____

Consumer Satisfaction Survey

Please help us improve this program by answering some questions about the services you have gotten over the past several months. We are interested in your honest opinions, good or bad. Please answer all the questions. Thank you very much. We appreciate your help.

(Circle your answer)

1. How would you rate the quality of service you and your child received?

   Excellent | Good | Fair | Poor

2. Did your child get the kind of service you wanted?

   No, definitely not | Not really | Yes, generally | Yes, definitely

3. Have these services met your child's needs?

   Almost all of his/her needs have been met. | Most of his/her needs have been met. | Only a few of his/her needs have been met. | None of his/her needs have been met.

4. How satisfied are you with the amount of help you and your child received?

   Quite dissatisfied | Indifferent or Mildly dissatisfied | Mostly satisfied | Very satisfied

5. Have the services your child has received helped you to deal with your child's problems?

   Yes, they helped a great deal. | Yes, they helped somewhat. | No, they didn't really help. | No, they seemed to make things worse.

6. If you were to look for help again, would you use these same services?

   No, definitely not | No, not really | Yes, generally | Yes, definitely

Sex Offender Protocol Endorsement Sheet

Client Name: _____ SS#: _____

DOB: _____ County: _____

Agency: _____

1. Has the client ever been adjudicated by a court for a sex offense? Yes: ___ No: ___
   Date(s):
   Offense(s):
   Disposition(s):

2. If no to the above, has the client ever been charged with a sex offense which was pled down to a lesser offense, which was adjudicated? Yes: ___ No: ___

3. Is a well-documented history of sexual offending behavior available? Yes: ___ No: ___
   If yes, summarize (include self-report, witness testimony, assessment, etc.):
   _____
   _____
   _____

4. Has an independent clinical assessment which documents the existence of the sexual problem been completed by a qualified child behavioral professional? Yes: ___ No: ___

5. Has the client ever received sex offender treatment? Yes: ___ No: ___

   Facility, agency, or therapist name:: _____ Telephone: _____
   Length of stay: _____
   Did the client successfully complete the program? Yes: ___ No: ___
   If no, identify the reason(s) for terminating treatment: _____
   _____

6. In what treatment program is the child being placed?
   Facility name and location: _____

7. Has the Parent Consent Form been signed? Yes: ___ No: ___

Please check one of the following:

___ Based on the information reviewed above, the designated agency representative confirms the need for residential sex offender treatment.

Signature: _____ Date: _____

___ Based on the information reviewed above, the designated agency representative denies the request for residential sex offender treatment

Signature: _____ Date: _____

Please note: Question 1, 2, or 3 must be checked "Yes" for the client to be eligible for residential care under the sex offender protocol.

CRITICAL INCIDENT REPORT

1. Name of program/level of care: _____
2. Location of incident: _____
3. Name of client: _____
4. Date of incident: _____(month, day and year) Time: _____ AM/PM (circle one)
5. Name of staff(s) involved in the incident: _____
6. Type of critical incident (check all that apply)

   - Attempted suicide by a client
   - Death of a client
   - Off-site emergency medical treatment (location: _____)
   - Off-site emergency assessment (location: _____)
   - Absence without leave/runaway (date and time of return: _____)
   - Possession of a weapon (type: _____)
   - Possession of an illegal substance (type: _____)
   - Report or involvement of an outside regulatory agency (agency involved: _____)
   - Placement in Seclusion or Restraints
   - Emergency change of placement:
     □ Discharge □ Hospitalization □ Incarceration □ Internal Transfer
     □ Other: _____
   - Removal from school:
     □ Suspension (# of days: _____) □ Expulsion □ Medical Homebound
     □ Homebased □ Other: _____
   - Other: _____

7. Describe the incident and the circumstances surrounding it (attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

8. What precipitating factors may have contributed to the incident? (attach additional pages if necessary)

_____

_____

_____

_____

_____

9. Describe the behavior management/intervention technique used to de-escalate the client and the client's response (attach additional pages if necessary):

_____

_____

_____

_____

_____

10. Describe follow-up actions taken (attach additional pages if necessary):

_____

_____

_____

_____

_____

11. NOTIFICATIONS	Name and Title of Person Notified/Agency Affiliation:	Date:	Time:	Name of Person Notifying:
Internal Staff				
Referring Agency				
Parent/Guardian				
Regulatory Agency				
Law Enforcement				
Other				

12. Signatures:

_____ _____

Signature and Title of Person Who Completed This Report — Date

_____ _____

Signature and Title of Clinical Reviewer — Date

_____ _____

Signature and Title of Administrative Reviewer — Date

_____ _____

Signature and Title of LIP (for seclusion and restraint only) — Date

Each report should be reviewed for completeness and quality by considering the following:

1. The information contained in the report is comprehensive and relevant.
2. The appropriate authorities/agencies, program/supervisory staff and parents/guardians were notified of the incident.
3. The actions taken in response to the incident were timely and appropriate.
4. The report is appropriately signed and dated.

FINANCIAL & STATISTICAL REPORT

1. Provider Name and Address:	
2. NPI and Provider's Medicaid Number:	3. E. I. Number:
4. Reporting Period: From:	To
5. Type of Control (check one): Voluntary Corporation [ ] Government: Federal [ ] State [ ] City [ ] Private for Profit [ ] County [ ] Other [ ]	
6. Site Location(s) covered by this report:	
7. Provider Agency Owned By:	
8. Service Information (check one): Moderate Management Rehabilitative Services [ ] Clinical Day Program [ ] High Management Rehabilitative Services [ ] Other (Specify): _____	

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I do solemnly swear (or affirm) that I have examined the information contained in this report; that all such information has been prepared from the books and records of the provider named within; that the aforesaid information is true and correct to the best of my knowledge and belief; and, that no other request for reimbursement from other federal and/or state funds has been made nor has any other reimbursement been received, applied for, nor will they be applied for, for the services herein described; that our agency has on file proper client authorization for these services claimed and the necessary documentation to support these claims; and, that all claims reported are within the period of authorized eligibility.

Signature (Officer or Administrator of Provider):	Title:	Date:
Report Prepared By:	Title:	Telephone:

For the Period beginning _____ **and ending** _____

Service Name: _____

EXPENSE & REVENUE REPORT

		(1)	(2)	(3)	(4)	(5)
	Personnel Services	Administrative Expenses	Treatment Expenses	Child Care Expenses (Room and Board)	Other Expenses	Total Expenses
1.	Salary and Wages					$0
2.	Social Security					$0
3.	Health Insurance					$0
4.	Retirement					$0
5.	Workers Compensation					$0
6.	Unemployment Compensation					$0
7.	Other Employer Contributions					$0
8.	Sub-Total Employer Paid Benefits	$0	$0	$0	$0	$0
9.	TOTAL PERSONNEL SERVICES:	$0	$0	$0	$0	$0

Provider's Name: _____

For the Period beginning _____ **and ending** _____

PERSONNEL SCHEDULE: ****

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Position	Total Hours Worked	Total Salary and Wages	$ allocated based on % of time to specified areas (Attach a narrative explanation of the basis of each allocation)			
			ADMIN.	TREATMENT	CHILD CARE	OTHER
	TOTAL:	$0	$0	$0	$0	$0

**** Do not include any positions and salaries on this page that are included in your indirect costs or management fees.

Provider's Name: _____

For the Period beginning _____ and ending _____

EXPENSE & REVENUE REPORT

CONTRACTUAL SERVICES	(1) Administrative Expenses	(2) Treatment Expenses	(3) Child Care Expenses	(4) Other Expenses	(5) Total Expenses
Printing & Advertising (recruitment of staff)					$0
Utilities (water, sewerage, etc.)					$0
Telephone & Telegraph					$0
Auditing, Accounting, & Finance					$0
Building Repairs					$0
Other Contractual					$0
TOTAL CONTRACTUAL SERVICES:	$0	$0	$0	$0	$0

SUPPLIES	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Office Supplies					$0
Household, Laundry, & Janitorial Supplies					$0
Educational Supplies					$0
Motor Vehicle Supplies (fuel, motor oil, etc.)					$0
Postage					$0
Food					$0
Building Maintenance Supplies					$0
Clothing					$0
Recreational Supplies					$0
Medical Supplies					$0
Other Supplies (including personal needs)					$0
TOTAL SUPPLIES:	$0	$0	$0	$0	$0

Provider's Name:

For the Period beginning _____ and ending _____

EXPENSE & REVENUE REPORT

	(1)	(2)	(3)	(4)	(5)
FIXED CHARGES	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Rent/Lease -- Real Property					$0
Rent/Lease -- Office Equipment					$0
Rent/Lease -- Motor Vehicles					$0
Insurance (other than fringe benefit)					$0
Other					$0
TOTAL FIXED CHARGES:	$0	$0	$0	$0	$0

TRAVEL	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Travel (meals, lodging, mileage)*					$0
TOTAL TRAVEL:	$0	$0	$0	$0	$0

*May not exceed State of South Carolina Travel Policies.

EQUIPMENT	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Interest					$0
Equipment Depreciation					$0
TOTAL EQUIPMENT:	$0	$0	$0	$0	$0

PERMANENT IMPROVEMENTS	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Interest					$0
Permanent Improvements Depreciation					$0
TOTAL PERM IMPROVEMENTS:	$0	$0	$0	$0	$0

TRAINING & EDUCATION OF STAFF (including memberships)	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Training and Education					$0
TOTAL TRAINING & EDUCATION:	$0	$0	$0	$0	$0

INDIRECT COSTS	Administrative Expenses	Treatment Expenses	Child Care Expenses	Other Expenses	Total Expenses
Indirect Costs					$0
TOTAL INDIRECT COSTS:	$0	$0	$0	$0	$0

TOTAL PROGRAM EXPENSES:	$0	$0	$0	$0	$0

Provider's Name: _____

For the Period beginning _____ **and ending** _____

EXPENSE & REVENUE REPORT

A. REVENUES RECEIVED:

		AMOUNT
1.	CONTRIBUTIONS:	
2.	MEDICAID	
3.	OTHER (please specify)	
4.		
5.		
6.		
7.		
8.	TOTAL REVENUES:	

B. **SERVICE INFORMATION:**

1. TOTAL NUMBER OF CLIENTS SERVED: _____
2. NUMBER OF MEDICAID ELIGIBLE CLIENTS SERVED: _____
3. TOTAL NUMBER OF UNITS PROVIDED: _____
4. NUMBER OF MEDICAID UNITS PROVIDED: _____
5. CAPACITY (Maximum number of units at 100% occupancy): _____

SUPPLEMENTAL SCHEDULE I

SCHEDULE OF FIXED ASSETS

	(1) Description	(2) Date Acquired	(3) Historical Cost	(4) Estimated Life	(5) Accumulated Depreciation	(6) Depreciation Expense
A.						
B.	Asset Additions - this period:					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
C.	Total Depreciation - Additions this period:					
D.	Total Depreciation - This reporting period:					

SUPPLEMENTAL SCHEDULE II

SCHEDULE OF PERMANENT IMPROVEMENTS

	(1) Description	(2) Acquisitior Date	(3) Historical Cost	(4) Estimated Life	(5) Accumulated Depreciation	(6) Depreciation Expense
A.						
B.	Permanent Improvements - this pe					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
C.	Total Depreciation - Permanent Improvements this period:					
D.	Total Depreciation - This reporting period:					

SUPPLEMENTAL SCHEDULE III
SCHEDULE OF OWNER(S)/RELATIVE(S) COMPENSATION:

A.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	OWNER(S) NAME	JOB TITLE	TOTAL HOURS WORKED	COMPENSATION DESCRIPTION	COMPENSATION AMOUNT	COST REPORT REFERENCE PAGE, LINE	DO YOU CLAIM COMPENSATION AT ANOTHER FACILITY OR PROGRAM? ***
1.							
2.							
3.							
4.							
A - 5.	TOTAL:						

B.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	RELATIVE(S) NAME	JOB TITLE	TOTAL HOURS WORKED	COMPENSATION DESCRIPTION	COMPENSATION AMOUNT	COST REPORT REFERENCE PAGE, LINE	DO YOU CLAIM COMPENSATION AT ANOTHER FACILITY OR PROGRAM? ***
1.							
2.							
3.							
4.							
B - 5.	TOTAL:						

C GRAND TOTAL:

*** If compensation is claimed at another facility or in another program, the other facility's name and/or program has to be identified. Attach additional pages as may be necessary.

SUPPLEMENTAL SCHEDULE IV
TRANSACTIONS WITH RELATED ORGANIZATIONS:

Does this facility participate in transactions with related organizations? Yes: ( ) No: ( )
If yes, the following information must be completed:

A. EXPENSES: (Supplies, rent, management fees, etc.)

	(1) RELATED ORGANIZATION NAME	(2) ITEM DESCRIPTION	(3) COST PER BOOKS	(4) COST TO RELATED PARTY	(5) COST REPORT REFERENCE PAGE, LINE
1.					
2.					
3.					
4.					
A - 5.	TOTAL:				

B. REVENUES:

	(1) RELATED ORGANIZATION NAME	(2) ITEM DESCRIPTION	(3) REVENUE PER BOOKS	(4) ACTUAL COST	(5) COST REPORT REFERENCE PAGE, LINE
1.					
2.					
3.					
4.					
B - 5.	TOTAL:				