# FORMS

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<td>DHHS 126</td>
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<td>Medicaid Refunds</td>
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<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
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<td>Duplicate Remittance Advice Request Form</td>
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<td>MAPPS Progress Report/Needs Assessment</td>
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<td>Standing Order (Sample)</td>
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<td>DHHS 687</td>
<td>Consent for Sterilization (two pages)</td>
<td>05/2019</td>
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</table>
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)

SCDHHS Form 126 (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:

<table>
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<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
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</tbody>
</table>

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

DHHS Form 205 (01/08)
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

DHHS 931 – Updated February 2018
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 THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS
PROCESSING POST OFFICE BOX.

Revised 04/2014
# Electronic Funds Transfer (EFT) Authorization Agreement

## Reason for Submission

- [ ] Change to Current EFT (i.e. account or bank changes)
- [ ] Individual  [ ] Organization

### Individual Provider/Organization Information

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<table>
<thead>
<tr>
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<th>State</th>
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<th>EIN (organization)</th>
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### Organization/Individual Provider EFT Contact Information

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### Financial Institution Information

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By signing this form, I authorize the SCDHHS to initiate credit entries, if necessary, debit entries for any credits in error to the checking or savings account at the financial institution identified above. Credit entries will pertain only to the SCDHHS payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the SCDHHS 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 30 days written notice to the address shown below prior to revoking or revising this authorization.

- [ ] I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit [https://sip.scdhhs.gov/sceis](https://sip.scdhhs.gov/sceis) or contact 888-289-0709.

**ALL EFT REQUESTS ARE SUBJECT TO A 10-DAY PRENOTE PERIOD IN WHICH ALL ACCOUNTS ARE VERIFIED BY THE QUALIFYING FINANCIAL INSTITUTION BEFORE ANY MEDICAID DIRECT DEPOSITS ARE MADE.**

### Signature of Person Submitting Form (print to sign)

### Printed Name of Person Submitting Form

### Submission Date

---

**SPECIAL INSTRUCTIONS:** For questions regarding the status of your EFT update, please contact the Provider Service Center at 888-289-0709. Please refer to the EFT section of the provider enrollment manual found at [https://www.scdhhs.gov/provider](https://www.scdhhs.gov/provider) for instructions on how to complete updates to your EFT information.

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

To process EFT updates, please return this completed form along with verification of your electronic deposit information on your financial institution’s letterhead to:

**SCDHHS, Medicaid Provider Enrollment • PO BOX 8809 • Columbia, South Carolina 29202-8809 • FAX 803-870-9022**

---

**EFT Authorization Agreement**

**Revision Date: July 30, 2019**
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

SCDHHS (Revised 09/01/17)
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 (DDS)”
W)aivers
☐ 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: ____________________________

SCDHHS CR Form (11/18)
Section 5: Desired Outcome

Request submitted by:

Print Name: __________________________

Signature: ___________________________ Date: __________
This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

| PROVIDER ID. | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE |
|--------------+------------------------+--------------+------|
| AB00080000   | DEPT OF HEALTH AND HUMAN SERVICES | 02/14/2014 | 1 |
| SOUTH CAROLINA MEDICAID PROGRAM | | | |

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<th>CLAIM</th>
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<th>TITLE 19</th>
<th>S</th>
<th>RECIPIENT ID.</th>
<th>RECIPIENT NAME</th>
<th>M</th>
<th>TLE. 18</th>
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<td>ID.</td>
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<td>S</td>
<td>NUMBER</td>
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|            | TOTALS | | | | | | | | |
|            | 310.00 | | | | | | | |

|$6.72|

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.

PHONE NUMBER: 000 00000

CERTIFIED AMT | MEDICAID TOTAL | E = ENCOUNTER |

CHECK TOTAL | CHECK NUMBER |

SAMPLE ONLY
Sample Remittance Advice (page 2)

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.

<table>
<thead>
<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
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<tr>
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<td>REMITTANCE ADVICE</td>
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<th>RECIPIENT NAME</th>
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<th>TLE.18</th>
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<th>TITLE</th>
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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

E = ENCOUNTER | F = MEDICAID | P = PAYMENT MADE

R = REJECTED | S = IN PROCESS | | ABC HEALTH PROVIDER

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IF YOU STILL HAVE QUESTIONS | IF YOU STILL HAVE QUESTIONS |

PO BOX 00000 |
FLORENCE SC 00000 |

Sample Only
Sample Remittance Advice (page 3)

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

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<thead>
<tr>
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<th>PAYMENT DATE</th>
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### Sample Remittance Advice (page 4)

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.

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**Check Number:** PO BOX 000000

**Provider:** FLORENCE SC 00000

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Note: The document is a sample remittance advice with detailed information about adjustments and financial transactions. The table structure and content are designed to provide clear and organized information for the recipient.
MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

DOCUMENTATION POINTS

**S9445-FP** — Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client’s response.

**S9446-FP** — Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client’s response.

1) Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
2) Information on the importance of family planning, responsible sexual behavior, and its effect on overall reproductive health
3) Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
4) Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
5) Discussion of the benefits of delaying pregnancy
6) Discussion of the long- and short-term health risks related to early sexual activity
7) Discussion of birth control methods, including abstinence, and the options available
8) Instruction on the proper and appropriate use of birth control methods
9) Importance of compliance with prescribed family planning methods and follow-up medical visits
10) Information on the benefits and risks of long-term birth control methods
11) Identification of family planning problems
12) Discussion of the availability of other health care resources related to family planning
13) Information on STDs and prevention of STDs as it relates to reproductive health and family planning
1. Name of Participant: (First, Middle Initial, Last)

2. Age of Participant: Date of Birth: Gender: □ Male □ Female

3. Social Security #: Medicaid #: Patient Account:

4. Eligibility: □ Medicaid □ Foster Care □ Child Protective Services

5. Date of Assessment: (Month, Date, Year)

6. Racial or Ethnic Background of Participant: (Check one)
   □ White or Anglo, Not of Hispanic Origin
   □ Black, Not of Hispanic Origin
   □ Hispanic
   □ American Indian
   □ Asian or Pacific Islander
   □ Other: ________________________________

7. Special needs of the participant: (Check All That Apply)
   □ None □ Attention Deficit Disorder (ADD) □ Learning Disability □ Emotionally Handicapped
   □ Other: (Specify) ________________________________

8. Does the participant have a primary medical care provider? If so, name and address:

   Managed Care Plan ________________________________


12. Marital Status of Parent(s): □ Married □ Single □ Separated □ Widowed □ Other: ______

   Environmental

13. Address of Participant:

   Street Address: ________________________________

   Mailing Address: (If Different from Street Address)

   City/Town: ________________________________

   State: ________________________________

   Zip Code: ________________________________

   Telephone: (Home): Other: □ No Telephone

14. Household Members:

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<thead>
<tr>
<th>Name</th>
<th>Relationship to Participant</th>
<th>Age</th>
<th>Grade</th>
<th>School or Place of Employment of Household Members</th>
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</table>

Rev. 07/17 Screen Form Parent - Page 1 of 1
MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

SCREENING FORM STUDENT

1. Name of Participant: (First, Middle Initial, Last) ____________________________________________

2. Age of Participant: _______ Date of Birth: ____________ Gender: □ Male □ Female

3. Social Security #: ______________ Medicaid #: ___________________________ Patient Account: _______

4. Date of Assessment: (Month, Date, Year) _________________________________________________

5. Access to Transportation: (Check One): □ Yes □ No Comment _____________________________

Referral/ Health Risk Factors

6. What was the referral source for MAPPS? (Check One)
   □ DSS □ Teacher □ Counselor □ Relative □ Friend □ Other: (Specify) ___________________________

7. Referral Risk Factor(s): (Explain in Narrative)
   □ Participant is a Teen Parent □ Participant is Sexually Active □ Participant has a history of Sexual Abuse
   □ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent (give details)

8. Is the participant currently sexually active? □ Yes □ No
   If no, has the participant ever been sexually active? □ Yes □ No

9. Has the participant ever been an expecting parent (abortion/fetal death)? □ Yes □ No

10. Has the participant ever used a birth control method? □ Yes □ No
    Method Used: (Check All That Apply)
    □ Birth Control Pills □ Condom □ Depo-Provera Shot □ Diaphragm □ IUD □ Rhythm
    □ Other: ____________________________

11. Does the participant understand or know the health risks associated with having sex? □ Yes □ No

12. Has the participant ever had a STD? □ Yes □ No If yes, specify: ___________________________

13. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? □ Yes □ No
    If yes, what kind? ____________________________

Activities

14. Does the participant engage in extracurricular activities? □ Yes □ No
    If yes, list activities: _________________________________________________________________

15. How does the participant spend his/her free time?
    After School: ________________________________________________________________________
    Weekends: ____________________________________________________________________________

16. Do household rules cause any conflict between the parent/guardian and the participant? □ Yes □ No
    If yes, explain: ______________________________________________________________________

What are the parent/guardian’s and the participant’s feelings about the household rules? ___________

17. Does participant have friend? □ Yes □ No
    If yes, gender and age? ________________________________________________________________
When they spend time together, what do they do? _________________________________

How does the participant get along with friends? ________________________________

18. How does the participant get along with adults? (Including teachers) ________________________________
CASE PLAN

Treatment Protocol (T1023-FP)

Participant’s Name ____________________________ Medicaid Number _______________________

Needs Statement:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Plan of Care:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Goals and Objectives | Frequency | Completion Date*
----------------------|-----------|------------------

* A Progress Report may be sent to the Primary Care Physician when services are completed.

This ICP will be reviewed on (6 months from ICP date): ________________________________

Participant’s Signature: ____________________________________________________________ Date: _____________

Parent/Legal Guardian’s Signature: ____________________________ Date: _____________

Provider of Service: ____________________________________________ Date: _____________

(Licensed/Certified Signature and Title)

Units: ______________

Date Reviewed: ____________________________ (Review case plan during Individual Session)

Progress Report prepared by: ____________________________ Date: _____________

Mailed to: ____________________________________________ Date: _____________

(Primary Care Physician)
MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

INDIVIDUAL OR GROUP SESSION FORM

Participant’s Name: ____________________________________________

Date of Service: ________________  DOB: ________________  Age: ______

Medicaid Number: ____________________  □ Individual  □ Group

Place:  ____________________________  Units of Service: __________

□ Participant’s Home  □ Office  □ School  □ Other

Risk Factors: (Check All That Apply)

□ Participant is a Teen Parent   □ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent
□ Participant is sexually and/or has a history of sexual abuse

A narrative description of services must be provided. Documentation of session must support time billed and points discussed. Check the Documentation Points discussed:

1. Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
2. Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health
3. Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
4. Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
5. Discussion of the benefits of delaying pregnancy
6. Discussion of the long and short-term health risks related to early sexual activity
7. Discussion of birth control methods, including abstinence, and the options available
8. Instruction on the proper and appropriate use of birth control methods
9. Importance of compliance with prescribed family planning methods and follow up medical visits
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11. Identification of family planning problems
12. Discussion of the availability of other health care resources related to family planning
13. Information on STDs and prevention of STDs as it relates to reproductive health and family planning

Revised: 01/2013  Page 1 of 2
PATIENT EDUCATION

[ ] Individual  [ ] Group

Participant’s Name: ____________________________
Date of Service: _______________  Medicaid Number: _______________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Service Provider
SIGNATURE (and credentials): _______________  Date: _______________

Supervisor
CO-SIGNATURE (and credentials)  Date: _______________
# MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

## PROGRESS REPORT/NEEDS ASSESSMENT

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<th>Reason for Communication:</th>
<th>□ Admission</th>
<th>□ Progress Report</th>
<th>□ Discharge</th>
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| Primary Care Physician: | __________________________ |
| Address: | __________________________ |
| | __________________________ |
| Phone/Fax: | __________________________ |

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<th>Name of Client:</th>
<th>Date of Birth:</th>
<th>Medicaid ID #:</th>
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</table>

| Date MAPPS Services Started: | |
|-----------------------------| |

| Reason For Service Provision (Risk Factor): | |
|--------------------------------------------| |

| Client Assessment: | |
|--------------------| |

| Status of Mutually Agreed Upon Goals/Target Dates: | |
|---------------------------------------------------| |

| Status of Plan of Care (Services/Frequency): | |
|------------------------------------------------| |

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<tr>
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| MAPPS Provider: | Telephone Number: | |
|-----------------|--------------------| |

**Signature of MAPPS Provider and Date:**
STANDING ORDER (SAMPLE)

In order for individuals to maintain an optimal state of health, it is imperative that they be linked with a Primary Care Physician (PCP) who provides medical preventive and acute care, that they use care appropriately, and that they practice healthy behaviors. \textit{(Insert Name of Facility)} staff may perform the following PSPCE and RSPCE:

- Assessment provided by Licensed Practitioner of the Healing Arts (LPHA) to determine client strengths, resources, perceptions of need relative to appropriate use of primary medical care, and practice of healthy behaviors;
- Evaluation of information and developing a plan of care in conjunction with the patient and PCP (must be verbal or written) which addresses health-related, medical, and developmental risks/needs appropriate for P/RSPCE;
- Determination of the patient’s risks and his or her readiness for intervention;
- Determination of interventions indicated, and whether interventions should be PSPCE or RSPCE;
- Implementation, coordination, and monitoring of the plan of care to determine patient progress toward goal achievement;
- Ongoing reassessment to determine necessary changes in the plan of care and/or interventions;
- Communication (must be verbal or written) will be maintained and documented in the clinical record during all phases of the patient’s care; and
- Identification of PCP (medical home):
  1. It is the responsibility of the PSPCE or RSCPE provider to assist the patient in locating a PCP within six months; to obtain permission to share PSPCE or RSPCE information with the PCP; and to communicate (must be verbal or written) the activities to the PCP during all phases of the patient’s care.
  2. This Standing Order may be used to authorize provision of PSPCE or RSPCE as long as efforts are being made to locate a PCP for the patient, but no longer than six months.

PSPCE may be provided by a LPHA as determined in the assessment in order to:
- prevent disease, disability, and other health conditions or their progression;
- prolong life; and
- promote physical and mental health efficiency.

PSPCE promotes full and appropriate use of medical care, promote positive health outcomes, prevents deterioration of chronic conditions, and enhances the practice of healthy behaviors.

RSPCE may be recommended by LPHA as determined in the assessment in order to reduce physical or mental disability and restore an individual to his or her best possible functioning level. This service also promotes changes in behavior, improves health status, and develops healthier practices to restore and maintain the patient at the highest possible functioning level.

P/RSPCE Dental Services

\begin{flushleft}
\underline{Signed by} \hspace{2cm} \underline{Date}
\end{flushleft}

\textit{Documentation Note: If this Standing Order is being used to authorize PSPCE or RSPCE, a copy must be placed in the patient’s chart.}
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

**CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from ______________________. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid, that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: ______________________

I, ______________________, hereby consent of my own free will to be sterilized by ______________________

by a method called ______________________

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

____________________________

Signature

____________________________

Date

[ ] Medicaid

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

- Hispanic or Latino
- Not Hispanic or Latino
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**INTERPRETER’S STATEMENT**

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

____________________________

Interpreter’s Signature

____________________________

Date

**STATEMENT OF PERSON OBTAINING CONSENT**

Before ______________________, signed the consent form, I explained to him/her the nature of sterilization operation ______________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization, which is permanent, is intended to be sterilized that his/her consent can be withdrawn at any time and that his/her will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

____________________________

Signature

____________________________

Date

**PHYSICIAN’S STATEMENT**

Shortly before I performed a sterilization operation upon ______________________ on ______________________

I explained to him/her the nature of the sterilization operation ______________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization, which is permanent, is intended to be sterilized that his/her consent can be withdrawn at any time and that his/her will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

____________________________

Signature

____________________________

Date

**INSTRUCTIONS FOR USE OF ALTERNATIVE FINAL PARAGRAPH**

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.

1. At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

   [ ] Premature delivery
   [ ] Individual's expected date of delivery: ______________________
   [ ] Emergency abdominal surgery (describe circumstances): ______________________

____________________________

Signature

____________________________

Date
PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HH Building, 200 Independence Avenue, SW, Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual’s consent, pursuant to any applicable confidentiality regulations [43 FR 32165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

HHS-687 (04/22)