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# 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:**

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<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
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**COMPLAINT:**

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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:

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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
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. 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.

Section 1: Beneficiary Information
Name (Last, First, MI): ____________________________________________
Date of Birth: ____________ Beneficiary Medicaid 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: ____________________________________________
Contact: ____________ Email: __________________________ Telephone #: ____________ Fax #: ____________
Street or Post Office Box: ____________________________________________ State: ____________ ZIP: ____________

Section 3: Claim Information
Communication ID: ____________ CCN: ____________ Date(s) of Service: ____________

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
□ Ambulance Services
□ Autism Spectrum Disorder (ASD) Services
□ Clinic Services
□ Community Long Term Care (CLTC)
□ Community Mental Health Services
□ Department of Disabilities and Special Needs (DDSN) Waivers
□ Durable Medical Equipment (DME)
□ Early Intervention Services
□ Enhanced Services
□ Federally Qualified Health Center (FQHC)
□ Home Health Services
□ Hospice Services
□ Hospital Services
□ Licensed Independent Practitioner’s Rehabilitative Services (LIPS)
□ Local Education Agencies (LEA)
□ Medically Complex Children’s (MCC) Waivers
□ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
□ Optional State Supplementation (OSS)
□ Pharmacy Services
□ Physicians Laboratories, and Other Medical Professionals Specify: __________________________
□ Private Rehabilitative Therapy and Audiological Services
□ Psychiatric Hospital Services
□ Rehabilitative Behavioral Health Services (RBHS)
□ Rural Health Clinic (RHC)
□ Targeted Case Management (TCM)
□ Other: __________________________

SCDHHS-OR Form (05/18)
Section 5: Desired Outcome

Request submitted by:

Print Name: ____________________________

Signature: ____________________________ Date: ____________
Sample Remittance Advice (page 1)

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

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| S$0.00 | $3975.25 | |

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

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER | |

| CHECK TOTAL | CHECK NUMBER | |

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ACME NURSING FACILITIES P.O. BOX 00000 | ANYWHERE SC 00000-0000 | | |

| PROVIDER NAME AND ADDRESS | | |

| SCHAP PG TOT | MEDICAID PG TOT | | |

EDITS: L00 673 L00 156 | | | |

ERROR CODE LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

| PROVIDER MANUAL | | |

| MEDICAID | |

ACME NURSING FACILITIES P.O. BOX 00000 | ANYWHERE SC 00000-0000 | | | |

| CHECK TOTAL | CHECK NUMBER | |

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER | |

| CHECK TOTAL | CHECK NUMBER | |

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |

ERROR CODE LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

| PROVIDER MANUAL | | |

| MEDICAID | |

ACME NURSING FACILITIES P.O. BOX 00000 | ANYWHERE SC 00000-0000 | | | |

| CHECK TOTAL | CHECK NUMBER | |

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER | |

| CHECK TOTAL | CHECK NUMBER | |

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |

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| PROVIDER MANUAL | | |

| MEDICAID | |

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| CHECK TOTAL | CHECK NUMBER | |

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER | |

| CHECK TOTAL | CHECK NUMBER | |

SCHAP TOTAL | MEDICAID TOTAL | S IN PROCESS | | |
Sample Remittance Advice (page 2)

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

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</table>

**DEBIT BALANCE**
- **MEDICAID TOTAL:** $3975.25
- **CERTIFIED AMT:** $0.00
- **TO BE REFUNDED:** $0.00

**REMITTANCE**

**ADJUSTMENTS**
- **ADJUSTMENTS:** $979.88
- **PROVIDER NAME AND ADDRESS:**
  - **ACME NURSING FACILITIES**
    - **P O BOX 00000**
    - **ANYWHERE SC 00000-0000**

**DEBIT BALANCE**
- **CHECK TOTAL:** $12424579
- **CHECK NUMBER:**

**TOTSALS**
- **00001**
- **-1044.12**
Notice of Admission, Authorization & Change of Status for Long Term Care

General Information

DHHS FORM 181 is utilized by Nursing Facilities (NFs), Intermediate Care Facilities for Individuals with Intellectual Disability (ICFIDs), Swing Bed Hospitals (SBs), and/or SCDHHS Medicaid Eligibility Workers. The DHHS FORM 181 is authorization by the Department of Health and Human Services for payment and reimbursement for NF, ICFID, and SB services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider Services. A DHHS FORM 845 should accompany all retroactive determinations over one year old for eligibility or recurring income.

Detailed Instructions

A. Section I – Identification of Provider and Patient:

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

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

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

For Authorization, send Form 181 to: SCDHHS Central Mail
Fax: (888) 820-1204
PO Box 100101
Columbia SC 29202

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

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

C. Section III – Authorization and Change of Status:

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

Co-Insurance

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

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

Distribution, Preparation and Routing of Form

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

A. Copy Submitted for Provider for claims processing at MCCS.

B. Copy Retained and kept on file by SCDHHS Medicaid Eligibility.

C. Original Retained and kept on file by the Provider of services.

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

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

Overnight delivery address:
MCCS-NF-AW-220
CLAIMS RECEIPT - NF CLAIMS SECTION
8901 FARROW ROAD
COLUMBIA, SC 29203-8260
**Notice of Admission, Authorization, and Change of Status for Long Term Care**

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

**Provider Fax Number:**

**Section I: Identification of Provider and Patient (Completed by Provider/Facility)**

1. **Beneficiary Name (First, Middle, Last)**
2. **Birth Date (MM-DD-YY)**
3. **Medicaid No. (10 digits)**
4. **Facility Name**
5. **Facility Street Address**
6. **County of Residence**
7. **Social Security No. - HIB Suffix**
8. **Provider Medicaid ID**
9. **Date of Request**
10. **Authorized Representative’s Name**
11. **Authorized Representative’s Phone No.**

**Section II: Type of Coverage and Statistical Data**

- **INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)**
  - [ ] SKILLED CARE (LOC)
  - [ ] INTERMEDIATE CARE (LOC)
  - [ ] SNF COINSURANCE (MEDICARE LOC)
- **CHANGE IN TYPE OF CARE: FROM**
- **TO**
- **DATE:** [ ]
- **ADMITTANCE DATE FOR:**
- **TRANSFERRED**
- **REMITTED FROM HOSPITAL STAY:** [ ] [ ]
- **NUMBER OF DAYS ABSENT FROM FACILITY:** [ ] [ ]
- **COVERED DAYS:** [ ] [ ]
- **TERMINATION DATE:** [ ] [ ]
- **DATE OF DEATH:** [ ] [ ]
- **RETURNED HOME (NOTIFY ELIGIBILITY):** [ ] [ ]
- **COINSURANCE DATES THIS BILL FROM** [ ] [ ]
- **THROUGH** [ ] [ ]
- **NO. OF DAYS:** [ ] [ ]
- **NON-COVERED MEDICAL EXPENSE:** [ ] [ ]
- **FORM 236 ATTACHED:** [ ] [ ]
- **ACTION:** [ ] [ ]
- **DATES OF SERVICE:** [ ] [ ]
- **ACTION:** [ ] [ ]
- **DATES OF SERVICE:** [ ] [ ]

**Section III: Authorization and Change of Status (Completed by DHSS EEMS Only)**

14. **Recommendation of DHSS Medicaid Eligibility Worker**
   - **Authorization to Begin Date:** [ ] [ ]
   - **Applicant not qualified for long term care because:** [ ]
   - **Financial Criteria Not Met** [ ]
   - **Non-Financial Criteria Not Met** [ ]
   - **Beneficiary’s Initial Applicable Recurring Income (Total Income Less Personal Allowance):** [ ] [ ]
   - **Change in Beneficiary Income (Total Income Less Personal Allowance):** [ ] [ ]
   - **Financially eligible, but waiting to be placed in a nursing home:** [ ]
   - **Personal Needs Allowance:** [ ] [ ]
   - **Other:** [ ] [ ]

**Section IV: Signature**

**Name of Eligibility Worker (Print):** [ ] [ ]

**Eligibility Worker Signature:** [ ] [ ]

**Date:** [ ] [ ]

DMHS Form 381 (May 2018) Page 2 of 2 Categorical Verification
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Approval of Non-Covered Medical Expenses

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

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

Regarding:   ______________________________                                          _________________________
(Beneficiary’s Name)                                                                         (Medicaid ID#)

| Part I                                                                                     |
| (To be completed by facility)                                                              |
| Description of item/service received:                                                     |
|_______________________________________________________________________________________|
|_______________________________________________________________________________________|
|_______________________________________________________________________________________|
| Reason item/service is a questionable deduction or needs prior approval:                  |
|_______________________________________________________________________________________|
|_______________________________________________________________________________________|
|_______________________________________________________________________________________|
| Cost of item/service:                                                                     |
|_______________________________________________________________________________________|

| Part II                                                                                     |
| (To be completed by SCDHHS)                                                                |
| Item/Service approved for deduction:                                                       |
|☐ Yes ☐ No (check one)                                                                     |
|If Yes, $__________________________ may be deducted.                                         |
|Signature:                                                                                  |
|_______________________________________________________________________________________|
|Date: ________________________________________________________________________________|
|Division of Medicaid Policy and Planning                                                    |

SCDHHS Form 235 (Rev. 07/08)
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Log of Incurred Medical Expenses

For the Month of _______________

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

Beneficiary's Name: 
____________________________________________________________________

Medicaid ID Number: 
____________________________________________________________________

Month: 
____________________________________________________________________

<table>
<thead>
<tr>
<th>Item/Service</th>
<th>Date Rendered</th>
<th>Date Bill Provided to Facility</th>
<th>Amount Billed for Item/Service</th>
<th>Lesser of Cost or Allowable Deduction</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

Total
______________________________________

Monthly Recurring Income (SCDHHS Form 181)  ______________________

Incurred Monthly Expenses  
(Not to Exceed Monthly Recurring Income)  ______________________

Amount carried over to next month**  ______________________

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

**If incurred monthly expenses exceed monthly recurring income, the difference can be carried forward to the next month. Put the difference on the first line of next month's log sheet. Include the statement "Prior Month Carry Forward" in the item/service line and the amount to be carried forward in the "Lesser of Cost or Allowable Deduction" column.
The following deduction amounts outlined replace amounts determined in 1989:

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

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

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

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

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

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

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

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

South Carolina Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, South Carolina 29202-8206
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMPLEX CARE PROGRAM SUPPLEMENTAL ASSESSMENT FORM

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

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Medicaid #</th>
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<table>
<thead>
<tr>
<th>Name &amp; Title of Staff Completing Form</th>
<th>Fax/Email</th>
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<tr>
<th>2nd Staff Contact Name &amp; Title</th>
<th>Fax/Email</th>
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<tr>
<th>Facility Completing Form</th>
<th>Date Completed</th>
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Initial Referral □ Recertification □ Requested Recertification dates: To From

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

Check Applicants Insurance: □ Medicaid □ Medicare A □ Medicare #

Category/Treatment | Additional Information | Documents to send with referral

Circle/blend in categories that apply to the applicant. Send admit note/H&P, insurance carrier(s), and supportive documents.

<table>
<thead>
<tr>
<th>□ Stage 4 /pressure ulcer only</th>
<th>(Attach staging note of stage 4 pressure wound only)</th>
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<table>
<thead>
<tr>
<th>□ Tracheostomy</th>
<th>□ Tracheostomy tube/cannula</th>
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<tr>
<th>□ Tracheostomy cleaning</th>
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<tr>
<th>□ Oral Suctioning</th>
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<table>
<thead>
<tr>
<th>By respiratory care unit or nursing facility staff</th>
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<tr>
<th>Purpose:</th>
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<tr>
<th>Frequency</th>
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<thead>
<tr>
<th>□ Total Parenteral Nutrition</th>
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<tr>
<th>□ Partial Parenteral Nutrition</th>
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<tr>
<th>Given by IV- Intravenous access only, No Antibiotics</th>
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<tr>
<th>□ Disruptive Behaviors 60% of the time requiring 1:1 assistance or restraints</th>
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<tr>
<th>List conditions /Behaviors:</th>
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<tr>
<th>□ Diagnosis of Morbid Obesity</th>
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<tr>
<th>(BMI 40 or higher and at least 100 pounds over ideal weight must include other d/x and need assistance with 1 ADL)</th>
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<tr>
<th>□ Bed</th>
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<tr>
<th>□ Lift Type</th>
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<thead>
<tr>
<th>□ Wheelchair</th>
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<tr>
<th>□ Goal directed therapies</th>
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<tr>
<th>Received therapist totaling 5 days per week for 2 of 3 disciplines.</th>
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<th>□ PT</th>
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<th>□ OT</th>
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<tr>
<th>□ LST</th>
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<tr>
<th>Frequency:</th>
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<tr>
<th>□ Ventilator Dependent</th>
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<th>(life sustaining for 6 or more hours a day)</th>
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<th>Name &amp; List settings</th>
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<table>
<thead>
<tr>
<th>□ Dialysis</th>
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<tr>
<th>Frequency</th>
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<tr>
<th>□ HIV (CD4 cell count equal to or less than 500)</th>
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<tr>
<th>Taking 2 or more medications for HIV treatment</th>
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<tr>
<th>(Attach medication list for HIV treatment)</th>
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SCDHHS Form 185S
August 2017
ADL SELF-PERFORMANCE—(Code for client’s PERFORMANCE during last 7 days—Not including setup)

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

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

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

4. TOTAL DEPENDENCE - Full caregiver performance of activity during entire 7 days

DEFINITIONS

A. TRANSFER - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)

B. LOCOMOTION - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair.

C. DRESSING - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.

D. EATING - How the client eats and drinks (regardless of skill).

E. TOILET USE - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

<table>
<thead>
<tr>
<th>TRANSFER</th>
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<tbody>
<tr>
<td>LOCOMOTION</td>
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<tr>
<td>DRESSING</td>
</tr>
<tr>
<td>EATING</td>
</tr>
<tr>
<td>TOILET USE</td>
</tr>
</tbody>
</table>


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

<table>
<thead>
<tr>
<th>CONTINENCE SELF-CONTROL CATEGORIES</th>
<th>(Code for client performance over 14 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. CONTINENT - Complete control</td>
<td></td>
</tr>
<tr>
<td>1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly</td>
<td></td>
</tr>
<tr>
<td>2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week</td>
<td></td>
</tr>
<tr>
<td>3. FREQUENTLY INCONTINENT - BLADDER, tends to be incontinent daily, but some control present; BOWEL, 2-3 times a week</td>
<td></td>
</tr>
<tr>
<td>4. INCONTINENT - Has inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOWEL CONTINENCE</th>
<th>Control of bowel movement, with appliance or bowel continence programs, if employed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLADDER CONTINENCE</td>
<td>Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants) With appliances (e.g., Foley) or continence programs, if employed</td>
</tr>
</tbody>
</table>

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

\[\square\text{Approved} \quad \text{Effective Date From} \quad \text{To} \quad \text{Date} \]

\[\square\text{Denied} \quad \text{Reason(s)} \quad \text{Date} \]

SCDHHS Representative ______________________ Date: ______________________

SCDHHS Form 1855
August 2017
SOCIAL HISTORY FOR MI LEVEL II PASARR SCREENING

Client Name: ________________________________________ CLTC #: ______________________

1. Appearance: ______________________________________

2. Ability to Communicate: ______________________________

3. Mental Status: _____________________________________

4. Observed Behavior: _________________________________

5. Current Living Situation: ____________________________

6. Significant Family History: __________________________

7. Social/Personal and Support Systems: ________________

8. Maladaptive/Inappropriate Behavior: _________________

9. Past Mental Health History: __________________________

10. Medical History & Impact of Medical Problems on Individual’s Functioning: _________________

11. Present Treatment: _________________________________

12. Summary/Comments: _______________________________

Signature: __________________________________________ Date: ____________________________

DHHS Form 247 (7/92)
The intent of the Social History is to obtain further information which relates to the MI indicators and is not normally included on the 1718 and Level I screening.

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

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

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

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

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

8) Comment further on behavioral indicators.

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

11) Comment on present mental health treatment.

12) Include informants, reliability of information, and a brief evaluation of client.
SOCIAL HISTORY FOR ID LEVEL II PASARR SCREENING

Client Name: ___________________________ CLTC #: ___________________________

1. Appearance: ________________________________________________________________

2. Ability to Communicate: _____________________________________________________

3. Mental Status: _____________________________________________________________

4. Observed Behavior: _________________________________________________________

5. Birth and Early Development History: ________________________________________

6. Social Development: _______________________________________________________

7. Social/Personal Significant Family History: _____________________________________

8. Independent Living Development/Ability: _______________________________________

9. Maladaptive/Inappropriate Behavior: __________________________________________

10. Medical History: ___________________________________________________________

11. Impact of Medical Problems on Individual’s Functioning: ________________________

12. Community Social Supports: ________________________________________________

13. Summary/Comments: _______________________________________________________

__________________________  __________________________
Signature:  Date:

DHHS Form 248 (4/17)
User’s Guide for Social History for ID Level II PASARR Screening

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

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

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

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

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

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

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

9. Comment further on behavioral indicators.

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

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

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

To: ________________  From: ________________

________________________

________________________

RE:

Dear: ____________________:

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

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

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

Sincerely,

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

May 15, 2007

DHHS Form 249
# South Carolina Psychiatric Evaluation

## I. Psychiatric History

### A. Hospitalizations

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

### B. Outpatient History

1. Has the patient ever been in outpatient treatment for one year or longer? **Yes** ____ **No** ____ **Unknown** ____
2. Which of the following services did the patient receive?
   - Counseling
   - Day Treatment
   - Short-term Outpatient
   - Crisis Intervention
   - Medication
   - Residential Treatment
   - Local Inpatient
   - Case Management

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

## II. Psychiatric Condition

### A. Affect

- Normal: **Y** ____ **N** ____ **U** ____________
- Angry: **Y** ____ **N** ____ **U** ____________
- Other (Describe): ____________________________________________
- Flat or blunt: **Y** ____ **N** ____ **U** ____________
- Labile or changeable: **Y** ____ **N** ____ **U** ____________
- Sad or blue: **Y** ____ **N** ____ **U** ____________
- Euphoric or elated: **Y** ____ **N** ____ **U** ____________

### B. Mood

- Depressed: **Y** ____ **N** ____ **U** ____________
- Anxious: **Y** ____ **N** ____ **U** ____________
- Normal: **Y** ____ **N** ____ **U** ____________
- Elated: **Y** ____ **N** ____ **U** ____________
- Fearful: **Y** ____ **N** ____ **U** ____________

### C. Thinking Patterns

- Incoherent or confused: **Y** ____ **N** ____ **U** ____________
- Loose or tangential: **Y** ____ **N** ____ **U** ____________
- Persevering or obsessive: **Y** ____ **N** ____ **U** ____________

DHHS Form 250 (1/92) 1
**NAME:**

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

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

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

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

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

1. **Cooperative:** An ease and confidence; give and take eye contact and animation.
   - Y N U
2. **Paranoid:** Guarded, suspicious, untrusting attributes; negative intent to questions and actions of others.
   - Y N U
3. **Withdrawn:** Little/no eye contact, pulling/turning away, asks to be left alone, volunteers little.
   - Y N U
4. **Resistive:** Withholding of information, answers brief and literal; gives little.
   - Y N U

**G. Speech.**

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

**H. Behavior.**

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

5. **Fearful:** Anxious about purpose or intent; physically holding self or pulls away; worries, frets.
   - Y N U
6. **Hostile:** Belligerent, angry, refuses to answer or deliberately misleads or misinforms; uncooperative.
   - Y N U
7. **Other (Describe):**
   ______________________________________________________
### III. INDEPENDENT EVALUATION REPORT AND RECOMMENDATION

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

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

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

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

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

**DIAGNOSIS:**

______________________________

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

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

Basis for these conclusions:

**Physician Signature:**

**Date:**
SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: _________________________________________ COUNTY OF RESIDENCE: ____________________________

SOCIAL SECURITY #: ____________________________ MEDICAID #: _______________________________________

LOCATION AT ASSESSMENT:

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

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

☐ According to Medicaid criteria, you meet the medical requirements to receive long-term care at the following level:
  ☐ SKILLED ☐ INTERMEDIATE

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

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

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

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

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

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

FOR LONG-TERM CARE FACILITY USE

☐ TIME-LIMITED CERTIFICATION, LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT’S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _________________________________________ Expiration Date: _________________________________________

Nurse Consultant Signature: ___________________________ Date: ___________________________

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

SENT: Date: ___________________________ Initials: ___________________________

DHHS FORM 185 (Nov. 2003)
As a Medicaid nursing home or home and community-based waiver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification:

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

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

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

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

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

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.
SOUTH CAROLINA COMMUNITY LONG TERM CARE

CONSENT FORM

Client Name: 

Social Security Number: 

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

This evaluation includes information provided by:

a. my physician and medical records;

b. professionals and organizations involved with my care; and,

c. an interview with me and, if necessary, with my family.

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

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

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

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

   

   

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

Date: ____________________________  
Signature of Client or Responsible Party

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

Date: ____________________________  
Signature of Witness

DHHS Form 121 (Revised 10/02)
### I. SCREENING FOR INTELLECTUAL DISABILITIES INDICATORS:

| 1. Diagnosis of intellectual disabilities or related disabilities made prior to age 22? |  
| 2. IQ tested below 70? |  
| 3. Was time of test prior to age 22? |  
| 4. Does client have 3rd grade education? If not, state reason in Comments Section. |  
| 5. Adaptive behavior: Could client ever perform self care activities? |  
| - Did he/she help care for spouse/parents/children? |  
| - Was client ever able to cook and perform household duties? |  
| - Was client gainfully employed? If not, explain in Comments Section. |  
| - Did client have driver’s license? |  
| 6. Cognitive Functioning: |  
| - Memory: Does client remember what he/she had for breakfast or lunch? |  
| - Simple math: Can client add 12 + 8? |  
| - Concept formation: Can client describe the difference between a fish and dog? |  
| 7. Comments: |  

### II. SCREENING FOR MENTAL ILLNESS INDICATORS:

| 1. Diagnosis of mental illness: No __ Yes __ Diagnosis: |  
| 2. History of psychiatric hospitalization within previous two years. (Give dates of treatment) If no hospitalization, indicate here: |  
| 3. Current behavioral indicators: |  
| Attempted suicide |  
| Assaulitive |  
| Incessant loud talking |  
| Uncooperative |  
| Hostile |  
| Unrealistic fear of strangers |  
| Self-mutilation |  
| Combative |  
| Social isolation |  
| Destruction of property |  
| None of these indicators: |  
| 4. Comments: (Include explanation of major symptoms): |  

DHHS Form 234 (4/17) Previous Editions are Obsolete.
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

NAME: _______________________________  SSN: _______________________________

III. LIST ALL PSYCHOTROPIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. _______________________________  4. _______________________________
2. _______________________________  5. _______________________________
3. _______________________________  6. _______________________________

IV. RECOMMENDATION OF REviewer:

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

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

V. PERTINENT INFORMATION

IMD admission requested; if so, indicate facility: _______________________________

Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: ____________________________________________________________________________

CLTC Area # ______

Signature and title of assessor: ____________________________________________________________________________________________

Agency/Institution completing form: _______________________________________________________________________________________

Admitting Nursing Facility: ___________________________________________  Date of Admission (if known) ______________

VI. ADVANCE CATEGORICAL DETERMINATION

FOR CLTC/IOC USE ONLY

Reviewed by Nurse Consultant ______ (initials)  Date Reviewed: _________________

Advance categorical determination that specialized services are not required:

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

Signature of CLTC Nurse Consultant: ________________________________

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

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

- Skilled Care
- Intermediate Care

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

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

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

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

Signature _______________________________ Effective Date ________________________

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

*(Less Than Intermediate Only)*
APPEALS

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

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

ALL APPEAL REQUESTS SHOULD BE SUBMITTED TO:

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

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

DHHS FORM 210 (REV. 08/11)
South Carolina Department of Health and Human Services
REQUEST FOR ASSESSMENT OF LEVEL OF CARE

From: ___________________________ DHHS

____________________________________

To: ________________________________

____________________________________

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

<table>
<thead>
<tr>
<th>Applicant</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Applicant:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Home Address:</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Social Security Number:</td>
<td>Date of Medicaid Application:</td>
</tr>
<tr>
<td></td>
<td>Category of Application:</td>
</tr>
<tr>
<td>Directions to Home:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized Representative</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Authorized Representative:</td>
<td>Relationship to Applicant:</td>
</tr>
<tr>
<td>Home Address:</td>
<td></td>
</tr>
<tr>
<td>Home Telephone Number:</td>
<td>Work Telephone Number:</td>
</tr>
</tbody>
</table>

Medicaid Worker’s Signature: _________________________ Date: _____________

DHHS Form 1231ME (June 2003)
A. Basic Infection Control Practices - 1 hour
   1. Describe basic infection control principles and proper handwashing techniques during meal service and feeding of a resident.
   2. Demonstrate proper handwashing technique.

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

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

D. Safety and Emergency Procedures - 1 hour
   1. Describe signs and symptoms of choking.
   2. Demonstrate management of obstructed airway (Heimlech Maneuver).
   3. Describe the facility’s emergency response plan, i.e., call system.

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

F. Principles of Observation and Reporting - 1 hour
   1. Describe how to observe a resident for changes inconsistent with their normal behavior.
   2. Describe how to report what is observed to the supervisory nurse.
Requirements of Paid Feeding Assistant Program

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

State Approval Guidelines for Paid Feeding Assistant Programs

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

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

Administrator/Coordinator Signature ____________________ Date ______________

Signature of DHHS Representative ____________________ Date ______________

Acknowledging Receipt of Agreement