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<th>Number</th>
<th>Name</th>
<th>Revision Date</th>
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<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
<td>06/2007</td>
</tr>
<tr>
<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
</tr>
<tr>
<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>01/2008</td>
</tr>
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<td>Reasonable Effort Documentation</td>
<td>04/2014</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>08/2017</td>
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<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
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<td>Claim Reconsideration Form</td>
<td>09/2017</td>
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<td>UB-04</td>
<td>Sample UB-04</td>
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<td>Sample Remittance Advice</td>
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<td>DHHS Certification of Need Psychiatric Hospital Services</td>
<td>07/2014</td>
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<tr>
<td></td>
<td>Notice of Non-Coverage for Inpatient Psychiatric Hospital Care (two pages)</td>
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<td>Sample Attestation Letter</td>
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<td>CALOCUS Score Sheet</td>
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<td>Death Reporting Worksheet</td>
<td>01/2010</td>
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<tr>
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<td>Quarterly Seclusion and/or Restraint Reporting Form</td>
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<tr>
<td></td>
<td>Serious Occurrence Reporting Fax Form</td>
<td>07/2017</td>
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</tbody>
</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>
<thead>
<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>
</tr>
</thead>
<tbody>
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</tr>
</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
or
Mail: 803-255-8225                        Post Office Box 8206, Attention TPL
Columbia, SC  29211-9804                     Columbia, SC  29202-8206

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

Medicaid Beneficiary ID: _______________________________   SSN: _________________________________
Carrier Name/Code: ____________________________   New Unique Policy Number: ______________________

Submit this information to South Carolina Department of Health and Human Services (SCDHH). Fax: 803-255-8225 or Mail: 803-255-8225 Post Office Box 8206, Attention TPL
or
Mail: 803-255-8225                        Post Office Box 8206, Attention TPL
Columbia, SC  29202-8206

DHHS 931 – Updated January 2008
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
South Carolina Department of Health and Human Services

Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name

Doing Business As Name (DBA)

Provider Address

Street

City

State/Province

Zip Code/Postal Code

Medicaid Provider Number

Provider Federal identification Number (TIN) or

Employer Identification Number (EIN)

National Provider Identifier (NPI)

Provider EFT Contact Information

Provider Contact Name

Telephone Number

Telephone Number Extension

Email Address

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution Address

Street

City

State/Province

Zip Code/Postal Code

Financial Institution Routing Number

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

Provider’s Account Number with Financial Institution:

Account Number Linkage to Provider Identifier (select one)

Provider Tax Identification Number (TIN)

National Provider Identifier (NPI)

REASON FOR SUBMISSION: □ New Enrollment □ Change Enrollment □ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicare services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and state funds and that any false claims, statements or documents to 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 reversing or rescinding this authorization.

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

Written Signature of Person Submitting Enrollment

Printed Name of Person Submitting Enrollment

Submission Date

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

Department of Health and Human Services

Medicaid Provider Enrollment

P.O. BOX 8899, COLUMBIA, S.C. 29602-8899

FAX (803) 870-8222

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-286-0728. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDDHS Provider web page for instructions on how to complete updates to your EFT information.

Effective December 9, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reconciliation Trace Number. This trace number will automatically be included in your SCDDHS electronic remittance advice. In order for the matching reconciliation 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 matching trace number and your ERA can be directed to the Provider Service Center at 1-888-286-0728.

EFT Enrollment Form Revision Date: August 1, 2017
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: ___________ Benefits 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: ____________________________________________________________

Street or P.O. Box: ___________________________ State: _______ ZIP: ______

Contact: ______________________ Email: ______________________ Telephone #: ___________ Fax #: ___________

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 □ 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) □ Nursing Facility Services
□ 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: __________________________________________

SCDHHSS-OR Form (03/17)
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________ Date: __________
<table>
<thead>
<tr>
<th>PROVIDER ID</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
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<td>AB00080000</td>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td>REMITTANCE ADVICE</td>
<td>02/14/2014</td>
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<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
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<td>PROC.</td>
<td>BILLING</td>
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| ABB2AA | 1403004804012700A | 101713 | 74176 | 259.00 | 0.00 | S | 1112233333 | M CLARK | 026 | 0.00 | 0.00 |       |
| ABB3AA | 1403004805012700A | 071913 | A5120 | 12.00 | 0.00 | R | 1112233333 | M CLARK | 000 | 0.00 | 0.00 |       |

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<th>STATUS CODES</th>
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<td>0.00</td>
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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATION OF NEED

Client’s Name: ___________________________ Date of Birth: _______________________

Social Security Number: __________________________

NPI or Medicaid Provider ID: __________________________

A review team has evaluated all of the information submitted by the physician and other professionals to justify the client's admission to __________________________ and certifies that:

( ) Documentation of comprehensive diagnostic assessment conducted within one (1) week by a LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, risk assessment; and

( ) Ambulatory services available in the community do not meet the current treatment needs of the client; and

( ) Prior treatment addressing presenting concern/problem has not been successful; and

( ) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

( ) The inpatient services can reasonably be expected to improve the client's condition or prevent further regression so that the inpatient services will no longer be needed.

OR

( ) According to current criteria, the client does not meet the requirements for Medicaid-sponsored inpatient psychiatric care.

This certification is not an approval for Medicaid to pay. Medicaid eligibility or continued eligibility must be established by the appropriate SCDHHS Eligibility Office.

TEAM PHYSICIAN’S PRINT NAME: __________________________________________
TEAM PHYSICIAN’S SIGNATURE: ___________________________ Date: __________

Physician’s NPI: ___________________________

Effective Date: _________ Check One: Interdisciplinary Team ___ Independent Team ___

OTHER TEAM MEMBERS' SIGNATURES, TITLES, AND DATE SIGNED: (A minimum of one signature must be present.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Print Name</th>
<th>Signature</th>
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SCDHHS/CON Form 6-2014 (Revised 07/2014)
PSYCHIATRIC HOSPITALS
FOR INDIVIDUALS UNDER AGE 21
SOUTH CAROLINA MEDICAID
NOTICE OF NON-COVERAGE FOR
INPATIENT PSYCHIATRIC HOSPITAL CARE

DATE __________________ NPI OR MEDICAID PROVIDER ID ____________________________

NAME OF CLIENT ________________________________________________________________

ADDRESS ______________________________________________________________________

CITY, STATE, ZIP CODE _____________________________________________________________________________

ATTENDING PHYSICIANS NAME ___________________ ATTENDING PHYSICIAN’S PHONE # _________________________

Dear: ______________________________________________

The purpose of this letter is to inform you that __________________________ Hospital:

( ) Has determined that your psychiatric hospital admission is not covered under the Medicaid program because
__________________________________________________________________________________________________________

( ) Has determined that further inpatient psychiatric hospital treatment is no longer medically necessary. Furthermore, (Check One):

☐ Your attending physician agrees that continued hospitalization is no longer needed.

☐ Your attending physician disagrees that continued hospitalization is no longer needed, but SCDHHS or its designee concurs with our facility.

If you elect to be admitted and/or remain in the hospital, you are financially liable for all costs of the care you receive except for any convenience services or items normally not covered by the Medicaid program, beginning on ____________. This determination does not mean additional psychiatric services are not needed. Medicaid reimbursement may be available for these additional services; however, you do not need inpatient hospital placement to receive these services. You should discuss, with your attending physician and/or a representative from the agency that made your placement, other arrangements for any further health care you may require.

This notice is not an official Medicaid determination. SCDHHS’ designee may serve as the Quality Improvement Organization authorized by the Medicaid program to review inpatient psychiatric hospital services provided to Medicaid clients in the state of South Carolina.

If you disagree with our decision, you may request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through the facility or directly to SCDHHS or its designee at the address listed below:

SCDHHS Division of Behavioral Health
Attention: PRTF Non-Coverage
Post Office Box 8206
Columbia, SC 29202-8206
SCDHHS or its designee will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the facility).

If you do not request a review by noon of the first working day after receipt of this notice you may still request that SCDHHS or its designee review at any point during your stay or within 30 days after you receive this notice, whichever is longer.

SCDHHS or its designee will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

If SCDHHS or its designee disagrees with the facility, you will be refunded any amount collected by the facility except for any convenience services or items normally not covered by Medicaid.

If SCDHHS or its designee agrees with the facility, you are financially responsible for all services beginning on _________________ through your discharge date unless you request an immediate review. If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you received notification from SCDHHS or its designee.

Sincerely,

Hospital Representative

c: Beneficiary
Attending Physician
Legal Guardian
Authorized Referral Entity
SCDHHS Division of Behavioral Health, Attn: Non-Coverage

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of non-coverage from __________________________ on ___________. I understand that my signature below does not indicate that I agree with this notice, only that I have received a copy of this notice.

Signature of beneficiary or legally responsible party _______________________________________________ Date ____________

Client or legally responsible party refused to sign this notice, but was told that this admission is not covered by Medicaid.

Witness _____________________________________________________________________________ Date ____________

Witness _____________________________________________________________________________ Date ____________
Sample Attestation Letter

An individual who has the legal authority to obligate the facility must sign this attestation.

[Name of the Psychiatric Residential Treatment Facility]
[Address]
[City, State, Zip Code]
[Telephone Number]
[Fax Number (if applicable)]

Provider Number

Dear <State Medicaid Director>:

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the <NAME of the FACILITY> hereby complies with all of the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA), SCDHHS or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 431.610, have the right to validate that <Name of the Facility> is in compliance with the requirements set forth in the Psych Under 21 rules, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the SCDHHS immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify SCDHHS if it is my belief that <Name of the Facility> is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature
Printed Name
Title
Date
**CALOCUS SCORE SHEET**

Record the applicable rating, criteria and comments for each dimension. Total your score and determine the recommended level of care.

<table>
<thead>
<tr>
<th>LEVEL OF CARE</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rating</td>
<td>Criteria</td>
</tr>
<tr>
<td>I. Risk of Harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Functional Status**</td>
<td></td>
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</tr>
<tr>
<td>III. Co-Morbidity**</td>
<td></td>
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<tr>
<td>IV-A. Recovery Environment</td>
<td></td>
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<tr>
<td>Level of Stress</td>
<td></td>
<td></td>
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<tr>
<td>IV-B. Recovery Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V. Resiliency and Treatment History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI-A. Acceptance and Engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child or Adolescent</td>
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<td></td>
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<tr>
<td>VI-B. Acceptance and Engagement</td>
<td></td>
<td></td>
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<tr>
<td>Parent or Primary Caretaker</td>
<td></td>
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</tbody>
</table>

**COMPOSITE SCORE** __________  **LEVEL OF CARE** _______  

**Bold** – Indicates independent criteria requires automatic admission to a higher level of care regardless of combined score. A score of 4 results in the placement at Level 5 and a score of 5 results in the placement at Level 6.  

**– For a score of 4, independent criteria may be waived if sum of IV-A and IV-B scores equal 2.

**Rater Name/Title:** ___________________________  **Date:** __________

**ADDITIONAL INFORMATION:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________  

When the CALOCUS score indicates a Level 4, 5 or 6, PRTF placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered.

Updated 10/2009
<table>
<thead>
<tr>
<th>DEATH REPORTING WORKSHEET - PRTFS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTACT INFORMATION</strong></td>
</tr>
<tr>
<td>RO contact’s name</td>
</tr>
<tr>
<td>Date of RO contact</td>
</tr>
<tr>
<td>RO contact’s phone number</td>
</tr>
<tr>
<td>Facility contact</td>
</tr>
<tr>
<td>Facility contact’s phone number</td>
</tr>
<tr>
<td><strong>PROVIDER INFORMATION</strong></td>
</tr>
<tr>
<td>PRTF Name</td>
</tr>
<tr>
<td>Medicaid Number</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Zip Code</td>
</tr>
<tr>
<td><strong>PATIENT INFORMATION</strong></td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Date of Birth/Age</td>
</tr>
<tr>
<td>Medicaid Number</td>
</tr>
<tr>
<td>Admitting Diagnoses</td>
</tr>
<tr>
<td>Date of Admission</td>
</tr>
<tr>
<td>Date/time of Death</td>
</tr>
<tr>
<td>Cause of Death</td>
</tr>
<tr>
<td>Did the facility conduct a root cause analysis</td>
</tr>
<tr>
<td><strong>NOTE: PRTFs may provide the following information over the telephone, or to the SA during its investigation</strong></td>
</tr>
<tr>
<td>Length of Time in restraints/Seclusion:</td>
</tr>
<tr>
<td>Circumstances Surrounding the Death:</td>
</tr>
<tr>
<td>Results of any facility investigation:</td>
</tr>
<tr>
<td><strong>RESTRRAINT/SECLUSION INFO</strong></td>
</tr>
<tr>
<td>Type of Restraint</td>
</tr>
<tr>
<td>Personal</td>
</tr>
<tr>
<td>Mechanical</td>
</tr>
<tr>
<td>Seclusion</td>
</tr>
<tr>
<td>Drug used as Restraint</td>
</tr>
<tr>
<td>Restraint Method</td>
</tr>
<tr>
<td>Reason(s) for Restraint/Seclusion use:</td>
</tr>
<tr>
<td>Less restrictive methods of behavior management considered:</td>
</tr>
<tr>
<td>Restraint/Seclusion order date/time:</td>
</tr>
</tbody>
</table>
**DEATH REPORTING WORKSHEET - PRTFS**

Quote actual restraint/seclusion order(s):

Restraint/seclusion ordered by: Physician _____ Other Licensed Practitioner _______ and Trained in use of emergency safety interventions? Yes _______ No _________

Was the resident’s treatment team physician contacted (unless same as ordering physician) Yes ______ No _________

Was the resident evaluated immediately after restraint removed/removed from seclusion? Yes _____ No ______

Monitoring method(s), frequency, last date/time monitored:

Last date/time of assessment:

**Additional Information/Comments:**

**Action Information**

**Facility notifications**

Other agencies the provider notified (SMA, SA, etc.):
Agency/date/time: ______________________________________________________
Agency/date/time: ______________________________________________________
Agency/date/time: ______________________________________________________
Agency/date/time: ______________________________________________________

**SA Action(s)**

Date of receipt of restraint/seclusion death report from PRTF: ________________________
Date of Survey: ________________________

**RO Actions(s)**

Date of receipt of restraint/seclusion death report from PRTF: ________________________
Date sent as complaint to SA (if applicable) ____________________________
Date/Method/Person notifying CO: __________________________________________

**CO Action(s)**

Date of receipt of initial restraint/seclusion death report from RO: ________________________
Date of receipt of restraint/seclusion death report worksheet: ________________________
Person recording the information: ____________________________________________
QUARTERLY SECLUSION AND/OR RESTRAINT REPORTING FORM

TO: SCDHHS Division of Behavioral Health

Name of Facility:

Name of Reporting Staff:

Facility Address: Facility Telephone (___) ___-____

---

**Reporting Data**

Quarter (list specific months):

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Medicaid ID</th>
<th>Staff Involved</th>
<th>Date and Time of Intervention</th>
<th>Location of Intervention</th>
<th>Type of Intervention (Seclusion or Restraint)</th>
<th>Reason for Intervention</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Reports must be submitted electronically in a secure format to behavioralhealth004@scdhhs.gov. Deadline for submitting reports is 30 days after the end of the quarter.

09/01/17
SERIOUS OCCURRENCE REPORT FAX FORM

TO: SCDHHS Division of Behavioral Health, Fax # 803.255.8204

<table>
<thead>
<tr>
<th>Name of Facility:</th>
<th>Facility Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Reporting Staff:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Address:</th>
<th>Facility Telephone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Identifying Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Name:</td>
</tr>
<tr>
<td>Resident Gender: ☐ Male ☐ Female ☐ Other</td>
</tr>
</tbody>
</table>

Please attach the Serious Occurrence report to this fax cover. The following items must be included with the Serious Occurrence Report.

☐ Name of resident(s) involved in the serious occurrence (a separate report must be submitted for each resident involved).
☐ Name, street address and telephone number of the facility
☐ Date and time of the occurrence
☐ Place of the occurrence
☐ Staff present during occurrence
☐ Names/Titles of staff notified of occurrence
☐ Detailed description of the occurrence (include precipitating factors, identify whether seclusion or restraint was utilized, immediate actions taken, follow-up action taken)
<table>
<thead>
<tr>
<th>Agency/Individual</th>
<th>Name/Title of Person Notified</th>
<th>Date/Time of Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protection and Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Caregiver/Guardian</td>
<td></td>
<td></td>
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<tr>
<td>Department of Health and Environmental Control</td>
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<tr>
<td>Other State Agency (if applicable)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attach additional pages as needed.

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