FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Reasonable Effort Documentation	04/2014
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
CMS-1500 (02/12)	Sample Claim Showing TPL Denial with NPI	02/2012
	Sample Remittance Advice	04/2014
DHHS 259	Interim Medicaid Targeted Case Management Transition Form w/Instructions (four pages)	04/2017
	Freedom of Choice	01/2016
	Freedom of Choice -Spanish	01/2016
	Fax Cover Sheet	03/2018
	MTCM Prior Authorization Request	03/2018
	Parent/Caregiver/Guardian Agreement to Participate in MTCM Services	01/2016
	Parent/Caregiver/Guardian Agreement to Participate in MTCM Services - Spanish	01/2016
	Corrective Action Plan	05/2021
	Homebuilders® Request for Approval of Continued Services/Booster Sessions	07/2024
	Targeted Case Management Referral	07/2024
	Targeted Case Management Brief Screening	07/2024

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #: _____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid: _____

☐ Medicare
( ) Full payment made by Medicare
( ) Deductible not due
( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)
☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)
☐ Explanation of Benefits (EOMB) from Medicare (if applicable)
☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

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)-ALLOW25DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID# _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _ _ _ _ _ _ _ _ _ _ _

Employer'sName/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) _____

ATTACHACOPYOFTHEAPPROPRIATEDOCUMENTATIONTOTHISFORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

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

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
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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections MEDICAID

Submit your claim Reconsideration request to:

Fax: 1-855-563-7086
or
Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone#: _____ Fax#: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (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: _____

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

Psychological Services
Sample Claim Showing TPL Denial
withNPI

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE | MEDICAID | TRICARE | CHAMPVA | PLAN | LI.NG | 01>6' | INSUAED'S | NUMBER

1234567890

2. PATIENI"SNAME (Ioot Nomo, FIrotNomo, Mldr:to InIIIol)

Doe, John A.

3. PATIENT'SBIRTH DATE | SEX

01 : 1999 MOO F

4- INSUAED'SNAME (Loot Nomo FIrotNomo, Mi d | Illo

5. PATIENrSADDRESS (No, SlrOet)

123 Windy Lane

6. PATIENT RELATIONSHIP TOINSURED

WS. O | S poIMD | ChIdD | OthorD

7. INSUREDS ADDRESS (No, SlrOet)

CITY

Anytown

STATE

SC

8. RESERVEDFORNUCCUSE

CIIY

ZIP CODE

29999

TELEPHONE (Include Area Code)

( )

ZIP CODE | TELE NE (Inctude

9, OTHa'IINSURED'SNAME ii. Mt Nome, FIrotNamo, MIdr:to InIIIol)

10. ISPATIENT'S CONDmONREI.A.TED TO<

11 1 'AED'SPO | G ROUPOR | NOM a'I

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D YES I&I C

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b. AUTOMX:

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d. INSURANCE PI.NI NAME OR PROGRAM NAME

401

10d. 9:" IMCODES( ) bYNUCC)

1

d, ISTWEREANOTHER HEALTH BENEFrTPLAN'!

DYES 0 NO

IIloltoml9, lla,and9d.

READ IIACK OF FORM BEFORE COMPLI!TINIL.IIIIININO111■ R) I'IIII.

12. PATIENT'SOR AUTHORIZED PERSO"8 SIGNATURII lo-1honil-o/ modloalll1o1h

Signature on File

13. INSUAED'SORAUTHORIZED PERSONS SIGNATUREI authorize

pay,-,tolmodc:albo nofIta to tI10 ..-.ri.,opl,yolclan orm,ppl,_foF

i--bacl-

14-DATE OF CURRENT: MM 1 DD 1 YY | QUAL

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM 1 DD 1 YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM 1 OO , VY FROM MM 1 OO , VY TO

17 NAMEOF REFERRING PI!ODER D(ER SOURCE

17a.

18. HOSPrDI;IV.IISU DATE\yREI.ATED TOC MM 1 1 FRO M TO MM 1 1

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAS? YES 0 No

ICHAR8EII

21. DWJNOSISORNATUREOF I ORINJ - #,-L loNMOO IInobolowfi!,4E) ICD Ind. 1

22. 'r4 ISSION OR IGINAi.REF. NO.

23- PRJORAUTHORIZATIONNUMBER

24. A. DATE(S)OF SERVICE | B. | C. | D. PROCEDURES. SERVICES, OR SUPPLIES | E. DIAGNOSIS POINTER | F. $CHARGES | G. | H. | I. | J. RENDERING PROVIDER ID. #

	From MM DD YY	To MM DD YY	PLACE OF	EMG	CPT/HCPS	Modifier				QUAL.	NPI
1	01 1 07 21	01 14 12	11		90304			60:00		NPI	1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDEJIAL TAXI.D. NUMBER | SSN EIN

555555555 18J

26. PATIENT'SACCOUNT NO.

DOE1 234

27. ACCEPT ASSIGNMENT? I&] ves

28. TOTAL.a-IARGE | 29. AMOUNTPAID | 30. RavdforNUCCU•

s 60100 $ 0 00 60100

31. SIGNATUREOF PHYSICIAN OR SUPPLIER INCLUDINGDEQREESOR CREDENTIALB (I that11'18 atallmanl9 on the rRWN IjIply totlliobil oncla A1.- a port- .)

SIGNED DATE

32. S ERVICE FAOIUTYLOOATION INFORM,\TION

33. BIW NB PROVIOER INFO & PHt (555)5555555

Jane Smit h, MD
111 Main Stree t
Anytown, SC22222-2222

Ib. L1234567890 ZZ1212121212

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 02/14/2014

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY	IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A					27.00	6.72	P	1112233333	M CLARK				
	01		101713		71010	27.00	6.72	P			026		0.00	0.00
ABB2AA	1403004804012700A					259.00	0.00	S	1112233333	M CLARK				
	01		101713		74176	259.00	0.00	S			026		0.00	0.00
ABB3AA	1403004805012700A					24.00	0.00	R	1112233333	M CLARK			0.00	
	01		071913		A5120	12.00	0.00	R			000			0.00
	02		071913		A4927	12.00	0.00	R			000			0.00
										Edits: L00 946 L02 852 08/30/13				
	TOTALS		3			310.00							0.00	0.00
							$6.72							

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

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

CERT. PG TOT: $0.00
MEDICAID PG TOT: $286.46
CERTIFIED AMT
MEDICAID TOTAL: 0.00
CHECK TOTAL
CHECK NUMBER

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

PROVIDER NAME AND ADDRESS
ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

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

PROVIDER ID. AB00080000 | DEPT OF HEALTH AND HUMAN SERVICES | SOUTH CAROLINA MEDICAID PROGRAM | PROFESSIONAL SERVICES | REMITTANCE ADVICE | PAYMENT DATE 02/28/2014 | PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	1405200415812200A				1192.00	243.71	P	1112233333	M CLARK			0.00	
	01		021814	S0315	800.00	117.71	P			000			0.00
	02		021814	S9445	392.00	126.00	P			000			0.00
	VOID OF ORIGINAL CCN 13283002244813300A PAID 20131018												
ABB222222	1405200077700000U				1412.00-	273.71-	P	1112233333	M CLARK				
	01		100213	S0315	1112.00-	143.71-	P			000			
	02		100213	S9445	300.00-	130.00-	P			000			
	REPLACEMENT OF ORIGINAL CCN 1304711253670430A PAID 20131018												
ABB222222	1405200414812200A				1001.50	42.75	P	1112233333	M CLARK			0.00	
	01		100213	S0315	142.50	42.75	P			000			0.00
	02		100313	S9445	859.00	0.00	R			000			0.00
												0.00	0.00

$286.46

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL". IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
	0.00

CHECK TOTAL

CHECK NUMBER

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

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

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

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG O D	CHECK DATE	ORIGINAL CCN
ABB222222	14052000777000000U				513.00-	197.71-	P	1112233333	CLARK		M		131018	1328300224813300A
	01		100213	S0315	453.00	160.71-	P					000		
	02		100213	S9445	60.00	33.00-	P					000		
	TOTALS	1			513.00-	193.71-								

PROVDER INCENTIVE CREDIT AMOUNT: 0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: $243.71

ADJUSTMENTS: $193.71-

CHECK TOTAL: $50.00

CERTIFIED AMT: 0.00

CHECK NUMBER: 4197304

0.00

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 4)

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

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 02/28/2014

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
							PAGE TOTAL:		4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	CHECK NUMBER
-4338.95	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL
0.00	0.00

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Interim Medicaid Targeted Case Management Transition Form

Beneficiary Identification:

Last Name _____ First Name _____ Initial _____

___/____/_____ Date of Birth _____ Medicaid # _____ Provider Client #

Current Targeted Case Management Provider:

Agency Name _____ Phone Number _____

Mailing Address: _____

Provider Contact Name and Fax Number _____

Interim Beneficiary Validation or Revalidation of Existing Beneficiary: Determine appropriate Target Group(s) and **describe** the beneficiary's behavior and circumstances which indicate the need/ medical necessity for Medicaid Targeted Case Management (MTCM) Services in the space below. The recommendation must be based on clinical information and the beneficiary's current situation. Attach supporting Psychiatric and/or Medical Assessment completed by Primary Care Physician, Psychological/Social Summary or discharge summary.

_____

_____

_____

_____

Target Groups – Circle the Appropriate Target Group(s)

(Target Group definitions can be found in the Targeted Case Management manual on the SCDHHS Web site: http://provider.scdhhs.gov.)

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Women and Children
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Similar Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

This interim form must be maintained in the beneficiary's MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

DHHS Form 259 (Revised - 04/01/17)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Interim Medicaid Targeted Case Management Transition Form

Medical Necessity Criteria:

- Beneficiary would benefit from a referral to services that are necessary to diagnose, treat, cure, or prevent an illness
- Beneficiary would benefit from a referral for services that would reduce, correct or ameliorate the physical, mental, developmental, or behavioral effects of an illness, injury or disability
- Assist the beneficiary to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities;
- The beneficiary, parent or caregiver is unable to provide adequate coordination of services.
- There is a lack of food, clothing, shelter, or other concrete resources that impact the health and well-being of the beneficiary.

Current or Past Service Providers:

List physicians, psychologist, and staff from providers such as DSS, DJJ, Continuum of Care, DDSN, Mental Health, School for Deaf and Blind, therapist, special education, Head Start, First Steps, and Drug and Alcohol treatment. Obtain signed releases and include dates of service if known.

_____

_____

_____

_____

_____

I recommend that the above named Medicaid beneficiary receive MTCM service(s). The beneficiary is aware that MTCM services are not required to receive Medicaid services to address identified needs.

By my signature, I attest that the beneficiary was provided an opportunity to choose from a list of enrolled Medicaid TCM providers. (Attach a copy of the signed and dated Freedom of Choice Form.)

_____ _____

Printed Name Case Manager's Signature

_____ _____

Title Date

This interim form must be maintained in the beneficiary's MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

DHHS Form 259 (Revised - 04/01/17)

INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANITION FORM 259 INSTRUCTIONS

Purpose

The purpose of this form is to provide a process for transitioning existing clients to the new MTCM system on or after January 1, 2013 and to also accommodate any new referrals until April 1, 2013 when the prior authorization (PA) process will be in place. The form must indicate the target group and provide the appropriate documentation to support medical necessity during the transition period from January 1, 2013 through March 31, 2013. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II implementation which will include (PA) based on documented medical necessity reviewed by SCDHHS or a quality improvement entity. The implementation for Phase II is projected to be April 1, 2013 and will include PA and the other reforms to the MTCM program.

Completion of transition Form 259

The form must be completed by the case manager during the three month transition period, but no later than March 31, 2013, and placed in the beneficiary's case file. The Office of Program Integrity at SCDHHS will not audit MTCM records during this transitional period for compliance on completion of Form 259 on dates of service after January 1, 2013.

Beneficiary Identification – self explanatory

Current Targeted Case Management Agency

This contact information will be used for the (PA) Process once Phase II is implemented in order to notify the agency of the PA status.

Interim Validation/Revalidation of Existing Beneficiary

This section should indicate if the beneficiary is a new referral or an existing beneficiary until Phase II is operational. The form should indicate the target group and provide the appropriate documentation to support medical necessity. Examples of supporting documents are provided on the form.

Target Groups

Circle the arrow in the left margin to indicate the appropriate target group(s).

Medical Necessity Criteria

This section is used to assist the person completing the validation portion of the form on what type of information helps define the Medical Necessity Criteria and does not require annotation.

Current or Past Service Providers

If additional information is required to meet medical necessity, this section provides information to the PA reviewer on previous and current services being rendered. Past services would include those provided within the last 6 months to a year.

INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANITION FORM 259
INSTRUCTIONS (Continued)

Freedom of Choice

As of January 1, 2013 the following providers of MTCM include:

Department of Social Services
Department of Disabilities and Special Needs
Department of Alcohol and Other Substance Abuse
School for the Deaf and Blind
James R. Clark Sickle Cell Foundation
Department of Mental Health
Department of Juvenile Justice
Continuum of Care
First Steps

Once other providers enroll, a list of qualified Medicaid providers geographically will be maintained on the agency web site. A Freedom of Choice form is attached.

South Carolina Department of Health and Human Services

FREEDOM OF CHOICE

This form should be completed after MTCM eligibility determinations have been made.

I have been informed of the Medicaid Targeted Case Management (MTCM) services available to me or my child. I understand I have a right to choose the provider of Medicaid Targeted Case Management services, and I have been given the opportunity to choose between enrolled Medicaid providers in my community setting.

As long as I remain eligible for MTCM services, I will continue to have the opportunity to choose between qualified MTCM providers.

I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

☐ I agree to receive Medicaid Targeted Case Management services for

_____ _____
Beneficiary Name Medicaid Number

I select _____ as my provider for MTCM Services.
Name of Provider

☐ I decline Medicaid Targeted Case Management Services.

_____ _____
Beneficiary Name Medicaid Number

_____ _____
Signature of recipient Date signed *(month, day, year)*

_____ _____
Signature of: *(check one)* _Family Date signed *(month, day, year)*
Guardian Witness

_____ _____
Signature of Case Manager Date signed *(month, day, year)*

DISTRIBUTION: Original - Provider Case File Beneficiary Copy

12/2012

Departamento de Salud y Servicios Humanos de Carolina del Sur
(South Carolina Department of Health and Human Services)

LIBERTAD DE ELECCION

Este formulario debe completarse despues de que se hayan realizado las determinaciones acerca de la elegibilidad para MTCM.

He sido informado/a acerca de los servicios de la Administraci6n de casos especfficos de Medicaid (Medicaid Targeted Case Management, MTCM) que se encuentran disponibles para mf *o* mi hijo/a. Entiendo que tengo derecho a elegir el proveedor de servicios de la Administraci6n de casos especfficos de Medicaid y que se me ha dado la oportunidad de elegir entre proveedores inscritos de Medicaid en mi comunidad.

Mientras siga siendo elegible para los servicios de MTCM, continuare teniendo la oportunidad de elegir entre proveedores de MTCM calificados.

Entiendo que tengo derecho a rechazar las servicios de MTCM. Si rechazo los servicios de MTCM eso no me impedira recibir otros servicios de Medicaid para las cuales pueda calificar.

D Acepto recibir los servicios de la Administraci6n de casos especfficos de Medicaid para

_____ _____
Nombre del beneficiario Numero de Medicaid

Selecciono a_____coma mi proveedor de servicios de **MTCM** Nombre del proveedor

D Rechazo las servicios de la Administraci6n de casos especfficos de Medicaid.

_____ _____
Nombre del beneficiario Numero de Medicaid

_____ _____
Firma del destinatario Fecha de firma *(mes, dia, ano)*

Firma de: *(se/eccione una opci6n)* _____
_ Familiar _ Tutor _ Test1go Fecha de firma *(mes, dia, ano)*

_____
Firma del Administrador de casos Fecha de firma *(mes, dia, ano)*

DISTRIBUTION: Original - Provider Case File Beneficiary Copy
12/2012

SOUTHCAROt NAO(PARTM[NTOfHEAI" ANOHUMANS(RVICU
Healthy Connectio ns
M EDI CAID, .

Henry McMaster GOVERNOR
Joshua O.Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

FAX COVER SHEET

CONFIDENTIAL INFORMATION ENCLOSED

DATE: .....

TO: SCDHHS - Division of Behavioral Health
Attn: MTCM Prior Authorization
Fax#: 803-255-8209

FROM: .....
Telephone#:
Email Address: .....
Contact Person: _____

Total Number of Pages Transmitted: ___ (Including Cover Sheet)

COMMENTS:

Long Term Care and Behavioral Health Services
P. 0. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2565 Fax (803) 255-8204

SOUTH CAROLINA OEPARTMENI OFHEALTH ANOHUMANSERVICES
Healthy Connections
MEDIC AID,

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 > Colurrbia, SC 29202
www.scdhhs.gov

MTCM Prior Authorization Request

Beneficiary Information	
Name:	
Address:	
Medicaid ID#:	
Date of Birth:	
Start date MTCM services:	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City/ State/ Zip Code:	
Phone Number:	
Fax Number:	

Diagnosis - Code/ Description: I

Target Population:

Procedure Code	Service Name	# of Units Requested

Rationale for Request
What service component(s) of TCM is the PA for?
D Assessment D Case Management Plan D Referral and Linkage D Monitoring and Follow-up

Rationale for Request
What specific need(s) will be addressed?
Are these new or ongoing needs? If the latter, please explain what prior MTCM services were provided to address and their outcome. Please describe specific activities that are planned to address the need(s) and estimated time frame for each specific activity
Has there been a recent change in the beneficiary's circumstances? (if yes, please explain)
Has there been a recent change in case manager? (if yes, please explain)

Disclaimer: An authorization is not a guarantee of payment. Beneficiary must be eligible at the time services are rendered, with medical necessity being met and service must be a MTCM service. Payment of service rendered is determined by the provider's timely claim submission.

Rationale for Request	
Rate the intensity of need:	D Severe D Moderate D Low
Case Manager Signature, Date and Credentials	
Case Manager Name (Print):	
Case Manager Signature:	Date:
Title:	Credentials:
Attachments	
1. Most recent Case Management Assessment (no more than 180 days old)	
2. Referrals made on behalf of beneficiary and reports and updates from service providers	
3. Most recent Case Management Plan	
4. Most recent review of the Case Management Plan	
5. **All** CSNs for **all** MTCM services rendered to beneficiary during the previous 30 days	
6. Parent/Caregiver/Guardian Agreement to Participate	
7. Fax Cover Sheet for MTCM Prior Authorization	
8. MTCM Prior Authorization Form	
Medicaid services are hereby:	☐ **APPROVED** ☐ **DENIED** **MTCM DHHS Staff Only**
JUSTIFICATION:	
MTCM Staff Signature:	**Date**

Disclaimer: An authorization is not a guarantee of payment. Beneficiary must be eligible at the time services are rendered, with medical necessity being met and service must be a MTCM service. Payment of service rendered is determined by the provider's timely claim submission.

Medicaid Targeted Case Management (MTCM)
Parent/Caregiver/Guardian Agreement to Participate in
MTCM Services

Name of Beneficiary: Date of Birth:
Medicaid Number:

What are Medicaid Targeted Case Management (MTCM) Services?
Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and services identification and referral. MTCM is a time-limited process that provides an organized and structured process for moving beneficiaries toward the goal of self-sufficiency.

- The MTCM process is a shared partnership between the beneficiary's parent/caregiver/guardian and the case manager.
- Parents/Caregivers/Guardians are actively involved in all phases of the process - assessment, planning, problem solving and identification of resources.
- MTCM ensures available resources are efficiently accessed and being used in a timely and cost effective manner.

South Carolina Medicaid allows provision of MTCM services to the following target population(s):

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Pregnant Women and Infants
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

The provider has provided adequate explanation to me that my child meets criteria for the following MTCM target population group(s):
(Circle one)

1) Yes 2) No, I need further explanation

What does South Carolina Medicaid expect of you?

A. You will be asked to:
   - Whenever possible, access your child's treatment needs on your own; MTCM is only for when you are unable to do this on your own or with the support of family and friends.
   - Participate in case management planning meetings.
   - Monitor your child's case management needs and report these to your child's MTCM case manager
B. You will be provided with links to community resources that may support you and your family and you will be expected to reach out to those organizations.
C. Based on your child's needs, you may be asked to engage in other specific interventions by your child's MTCM service provider

What canyou expect of your MTCM provider?
You can expect your provider to:

- Explain the purpose of all interventions in language that you understand
- Explain all known benefits and risks of the interventions in language that you understand
- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team

- Coordinate times and frequency of visits with you and to let you know in advance if he/she has to cancel or reschedule a visit
- Discuss the child's progress with youduring every visit
- Answer any questions you have regarding the child's treatment
- Respond to all concerns you express to them in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in **these servicesevery ninety (90) days.**

By signing this form, I:

- Agree that I as parent/ caregiver guardian need MTCM on behalf of my child in the following areas:

- Give permission for , the beneficiary, to participate in the following recommended MTCM Services:

- Acknowledge that the provider has explained the target population(s) in which my child meets criteria and how he or she meets that criteria.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I further understand that services can be immediately terminated upon my request unless these services are court ordered.

Printed Name of Parent/Caregiver/Guardian

Relatio nship to Beneficiary

Signature of Parent/Caregiver/Guardian

Date

I hereby attest that I have provided adequate explanation of: the criteria for the identified MTCM target population to the Parent/Caregiver/Guardian; how the child meets this criteria; and (as applicab le) that the child will be receiving behavioral health services.

Printed Name of Staff

Signature and Credentials of Staff

Date

Name of Provider

Administra ci6n de casos especificos de Medicaid (MTCM) Acuerdo del padre/la madre/el cuidador/el tutor para participar en los servicios de MTCM

Nombre del beneficiario: Fecha de nacim iento :
Numero de Medicaid:

,Para quesirven los servicios de Administracionde casos especificos de Medicaid (MTCM)?

Los servicios de Administraci6n de casos especificos de M edicaid (Medicaid Targeted Case Management, MTCM) constitu yen un medio para alcanzar el bienestar del beneficiario mediante la comunicaci6n, la educaci6n, y la ident ificaci6n y la d erivaci6n de servicios. MTCM es un proceso de tiempo limitado que proporciona un proceso organizado y estructurado para ayudar a los beneficiarios a alcanzar el objetivo de la autosuficiencia .

El proceso de MTCM constituye una asociaci6n compartida entre el padre/la madre/el cuidador/el tutor del beneficiario y el administradorde casos.

El padre/ la madre/los cuidadores/tutores participan activamente en todas las fases del proceso (la evaluaci6n, planificaci6n, resoluci6n de pro blemas e identificaci6 n de los recursos).

MTCM garantiza el acceso eficiente a los recursos disponibles y que se los uti lice de forma oportuna y rentable.

Medicaid de Carolina del Sur (South Carolina M edicaid) permite el suministro de los servicios de MTCM a la **siguiente poblacion especifica:**

Personas con discapacidades intelectu ales o relacionadas.
Ninos en riesgo.
Adultos con enfermedades mentales graveso persistent es.
Embarazadas y bebesen riesgo.
Personas con tr astorn o por el consume de sustancias psicoactivas.
Personas en riesgo de sufrir trastornos geneticos.
Personas con lesiones en la cabeza o en la medu la 6sea y discapacidades relacionadas.
Personas con discapacidades sensoriales.
Adultos con discapacidad es func ionales.

El proveedor me ha explicado de maner a adecuada que mi hijo/ a cumplecon los requisitos para el siguientegrupo de poblacion especifica para MTCM:
(Encierre en un circulo una sola opcion)

1) Si 2) No, necesit o mas explicaciones

lQue espera Medicaid de Carolinadel Sur de usted?

A. Se le pedira que:
   - Cuando sea posib le, acceda por sf m ism o a las necesidades de tratamiento de suhijo/ a; MTCM **solamente** debe utilizarsepara cuando usted no pueda hacerlo por si mismo o con el apoyo de familiares o amigos.
   - Participe en las reuniones de planificaci6n de la administraci6n de casos.
   - Supervise las necesidades de administraci6nde casos de su hijo/a *e* inf6rmelasal administrador de casos de MTCM de su hijo/a.
B. Sele proporcionara informaci6nsobre enlaces para obtener recursos de la comunidad que le puedan ayudar a usted ya su familia, y usted debera comunicarse con esas organizaciones.
C. Con re laci6n a las necesidades de su hijo/a, el proveedor de servicios de MTCM de su hijo/a podria pedirle que participe en otras intervencionesespecificas.

lQue puede esperar usted de su proveedor de MTCM?

Usted puede esperar que su proveedor:

- Explique el prop6sito de todas las intervenciones uti lizando un lenguaje que usted pueda entender .
- Explique todos los beneficios y riesgosconocidos de las intervenciones utilizando un lengua je que uste d pueda entender.
- Lo trate conrespeto a usted ya todos los miembros de su familia.
- Lo trate como miembro imprescindible del equipo de tratamiento.

- Coordine con usted el momento y la frecuencia de las visitas, y que le informe con anticipaci6n si debe cancelar o reprogramar una visita.
- Analice el progreso de su hijo/a con usted en cada visita.
- Responda cualquier pregunta que usted tenga en relaci6n con el tratam iento de su hijo/a.
- Responda a todas las inquietudes que ustedexprese de manera oportuna y respetuosa.
- Le brinde informaci6n acerca de los recursos de la comunidad.

Debido a que su participaci6n es clave para conseguir un resultado satisfactorio, cada noventa (90) dfas se le pedira que confirme suvoluntad para participar en estos servid os.

Al firmar este formulario, yo:

- Acepto que como padre/madre/cuidador/tutor, yen nombre de mi hijo/ a, necesito los servicios de MTCM en las siguientes areas:

  Brindo mi autorizaci6n para que , el beneficiario, participe en los siguientes Servicios de MTCM recomendados:

  Reconozco que el proveedor me ha explicado la poblaci6n especifica para la cual mi hijo/a cumple los requisitos y la manera en que el o ella cumple dichos requisitos.

Entiendo queen cualquier momento puedo informar al personal, ya sea de forma escrita o verbal, que yo (a) ya no deseo participar en estos servicios; o (b) ya no deseo que mi hijo/ a reciba estos servicios. Tambien entiendo que el suministro de los servicios puede interrumpirse de forma inmediata cuando yo lo solicite, a menos que un tribunal ordene que se brinden estos servicios.

Nombre en letra de molde del padre/madre/persona a cargo del cuidado/tutor

Relacion con el beneficiario

Firma del padre/madre/persona a cargo del cuidado/tutor

Fecha

Por el presente certifico que he explicado de manera adecuada lo siguien te : los crit eri os de iden tificaci6n para la po blaci6n especifica de MTCM al padre/madre/cuidador/tutor; la manera en que el niiio/la niiia cumple los requisites; y (segun corresponda) que el niiio/la niiia recibira servicios de salud conductual.

Nombre en letra de molde del personal

Firma y credenciales del personal

Fecha

Nombre del proveedor

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

The Division of Behavioral Health Corrective Action Plan

Provider Name			
Contact Person		**Phone Number**	
Contact Email		**Fax Number**	
Date Submitted to SCDHHS			

Item # on Summary	Opportunity for Improvement	Corrective Action Steps to be Implemented	Person(s) Responsible for Implementation	Target Date to Implement Corrective Action	Completion Date for Implementation
1					
2					
3					
4					
5					

Additional questions to be addressed:

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

HOMEBUILDERS®

Request for Approval of Continued Services/Booster Sessions

Member Name: _____

Member Medicaid ID#: _____

Provider Name: _____ **Homebuilders Start Date**:_____

Provider Contact Information (Phone Number and Email Address):_____

_____

Primary Diagnosis: _____

Secondary Diagnosis(es): _____

Does the youth continue to meet Homebuilders medical necessity criteria? ***YES*** _____ ***NO*** _____

Brief Description of Continued Stay Request and Medical Necessity *(attach additional information as necessary)*: _____

_____

_____

_____

_____

_____

Continued services are requested from _____(date) **to** _____ (date), **for a total of** _____ **additional units of service** (number of per diems requested).

**Completed form must be submitted as an attachment to 21st service claim via the Medicaid webtool if services not completed in initial 20 encounters.*

Questions or other inquiries may be submitted to behavioralhealth004@scdhhs.gov.

Homebuilders Supervisor Printed Name: _____

Homebuilders Supervisor Signature _____**Date:**_____

Homebuilders Consultant Printed Name: _____

Homebuilders Consultant Signature:_____ **Date:**_____

SCDHHS Office of Behavioral Health Approval: **YES**_____ **NO**_____

Approver Name: _____ **Date:**_____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Targeted Case Management Referral

Beneficiary Information

Beneficiary Name: _____ _____ _____
Last *First* *M.I.*

Beneficiary Date of Birth: _____ Medicaid ID: _____ Date of Referral: _____

Beneficiary Phone Number: _____ Beneficiary Email: _____

Parent/Guardian Name (If Applicable): *Last* _____ *First* _____

Diagnosis Code/s: _____

Referral Instructions

(1) Complete sections 1, 2, and 3 of the form.
(2) The Referral Form is only valid for 90 days. If a member requires services beyond 90 days, submit a new Referral Form prior to the referral end date.

1. Referral Source Information:

Provider/agency name: _____
Address: _____
Phone number: _____
TIN: _____ NPI: _____

Name of person completing form: _____
Contact information: _____ _____
Phone *E-mail*

2. Referral Indicators:

Note which areas require attention (Choose as many as applicable).

☐ Medical ☐ Social ☐ Psychosocial ☐ Educational ☐ Vocational

☐ Financial ☐ Housing ☐ Transportation ☐ Food Insecurity ☐ Other

Briefly describe the reason for referral for each indicator chosen above:

3. Referrer Signature:

I attest that the information on this form is true and accurate to the best of my knowledge.

Printed name

Signature

Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Targeted Case Management Brief Screening

Beneficiary Information

Beneficiary Name: _____ _____ _____
Last *First* *M.I.*

Beneficiary Date of Birth: _____ Medicaid ID: _____ Date of Screening: _____

Beneficiary Phone Number: _____ Beneficiary Email: _____

Parent/Guardian Name (If Applicable): *Last* _____ *First* _____

Diagnosis Code: _____

Presenting Concerns(s)/Immediate Needs

Provide a brief description of the Beneficiary's strengths, needs, and preferences in each of the following areas. If there is no presenting problem or goal in an area, note as non-applicable.

Medical: _____

Social: _____

Psychosocial: _____

Educational: _____

Vocational: _____

Financial: _____

Housing: _____

Transportation: _____

Food Insecurity: _____

Other: _____

Other Providers or Agencies

List all other providers or agencies currently being utilized by the Beneficiary. Include the purpose of utilization and phone number, if known.

1. _____
2. _____

3.
4.
5.

Supports and Services

Note any family or friends that are a source of support:

List other sources of support in the community, such as church or other organization involvement:

If the Beneficiary is not connected to peer supports, do they want to be referred?

Disposition

Case management recommended? ☐ Yes ☐ No *(Inform client access to CM is available if future need arises)*

Case Management accepted? ☐ Accepted ☐ Declined

x _____

Beneficiary Signature:_____ **Date:**_____

OTHER IMMEDIATE REFERRALS MADE: (include contact name)

Hospital/Clinic:		Reason:	
Agency:		Reason:	
Agency:		Reason:	
Internal:		Reason:	
Internal:		Reason:	