## FORMS

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>01/2008</td>
</tr>
<tr>
<td></td>
<td>Authorization Agreement For Electronic Funds Transfer</td>
<td>03/2011</td>
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<tr>
<td></td>
<td>Duplicate Remittance Advice Request Form</td>
<td>10/2012</td>
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<tr>
<td></td>
<td>Sample Remittance Advice</td>
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<td></td>
<td>Sample Turn Around Document</td>
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<tr>
<td>DHHS 2503</td>
<td>Annual Competency Evaluation Documentation</td>
<td>01/2003</td>
</tr>
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<td>(two pages)</td>
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<tr>
<td>DHHS 2504</td>
<td>IPC Personnel Competency Evaluation Form</td>
<td>01/2003</td>
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<td>DHHS 2501</td>
<td>IPC Program Referral</td>
<td>11/2003</td>
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<tr>
<td>DHHS 2502</td>
<td>Consent Form</td>
<td>01/2003</td>
</tr>
<tr>
<td>DHHS 2505</td>
<td>IPC Service Care Plan Elements (two pages)</td>
<td>01/2003</td>
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<tr>
<td>DHHS 2500</td>
<td>Sample Service Care Plan</td>
<td>01/2003</td>
</tr>
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<td>DHHS 175</td>
<td>IPC Service Provision Form</td>
<td>07/1992</td>
</tr>
<tr>
<td>DHHS 2507</td>
<td>Daily Task Log (two pages)</td>
<td>01/2003</td>
</tr>
<tr>
<td>DHHS 2506</td>
<td>Daily Census Log (two pages)</td>
<td>07/2003</td>
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<tr>
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<td>IPC Notification Form</td>
<td></td>
</tr>
<tr>
<td>CRCF-01</td>
<td>Notice of Admission, Authorization &amp; Change of Community Residential Care Facility</td>
<td>01/2003</td>
</tr>
<tr>
<td>DHHS 175-B</td>
<td>IPC Service Termination Notice</td>
<td>07/1994</td>
</tr>
</tbody>
</table>
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

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

Medicaid Beneficiary ID: ___________________________  SSN: ___________________________
Carrier Name/Code: ___________________________  New Unique Policy Number: ___________________________

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

DHHS 931 – Updated January 2008
South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION
Provider Name ____________________________
Medicaid Provider Number ____________________________
Provider NPI Number ____________________________
Provider Address ____________________________
City ____________________________ State __________ Zip

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

Financial Institution Name ____________________________
Financial Institution Address ____________________________
City ____________________________ State __________ Zip
Routing Number (nine digit) ____________________________
Account Number ____________________________

Type of Account (check one) □ Checking □ Savings

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.
I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.
I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: ____________________________ Phone Number: ____________________________
Signed ____________________________ (Signature)
__________________________________________ (Print)
Title ____________________________ Date ____________________________

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

RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:
Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

EFT/Revised 03/11
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 Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at [http://www.scdhhs.gov/contact-us](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: ________________  
4. Telephone Number: ________________

5. Requesting:
   - [ ] Complete Remittance Package
   - [ ] Remittance Pages Only
   - [ ] Edit Correction Pages Only

6. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   ____________________________________________
   ____________________________________________
   ____________________________________________

7. Street Address for delivery of request:
   Street: ________________________________
   City: ________________________________
   State: ________________________________
   Zip Code: ________________________________

8. Charges for a duplicate remittance advice 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 10/2012)
<table>
<thead>
<tr>
<th>LINE</th>
<th>Recipient Name</th>
<th>Social Security ID</th>
<th>Date of Service</th>
<th>Days</th>
<th>Income</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>GERALDINE ALSTON</td>
<td>28899900001</td>
<td>11/01/02</td>
<td>10</td>
<td>$000.00</td>
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<tr>
<td>LINE</td>
<td>COUNTY</td>
<td>NAME</td>
<td>ID NO</td>
<td>MONTHLY SERVICE CRCP</td>
<td>IPC // CHANGED</td>
<td>CRCP DAYS</td>
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</tr>
<tr>
<td>01</td>
<td>32</td>
<td>MARY SMITH</td>
<td>123456780</td>
<td>02/03</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>32</td>
<td>SAM PERKINS</td>
<td>987654320</td>
<td>02/03</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

1) IF THE ABOVE INFORMATION IS CORRECT AND THERE HAVE BEEN NO ADMISSIONS OR DISCHARGES, SIGN AND DATE AS INDICATED BELOW.
2) IF THERE HAS BEEN A NEW OSS APPROVED ADMISSION TO YOUR FACILITY DURING THE MONTH OF DECEMBER, ENTER A NEW LINE FOR THAT RESIDENT WITH THE NAME, ID NUMBER, DATE OF ADMISSION, AND NUMBER OF DAYS IN YOUR FACILITY.
3) IF THE FACILITY HAS RECEIVED AUTHORIZATION FROM SC DHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCP DAYS BY THE NUMBER OF DAYS THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES AND INSERT THE NUMBER OF DAYS THE RESIDENT RECEIVED AUTHORIZED IPC SERVICES IN THE IPC DAYS COLUMN.
4) IF THERE HAS BEEN A DISCHARGE/DEATH FROM YOUR FACILITY DURING THE MONTH OF DECEMBER, INDICATE THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH, THAT THE RESIDENT WAS IN YOUR FACILITY IN THE COLUMN TITLED "CHANGED CRCP DAYS". IF THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES, ENTER THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY AND WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES IN THE "CHANGED IPC DAYS" COLUMN.
5) IF ANY OF THE RESIDENTS LISTED WILL NOT BE IN YOUR FACILITY NEXT MONTH, ENTER AN 'X' IN THE COLUMN TITLED 'DELETE FROM NEXT MONTH'S TD'.

I CERTIFY THAT THE INFORMATION SHOWN ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO GENERATE PAYMENTS OF STATE FUNDS, AND I UNDERSTAND THAT SUBMITTING FALSE OR MISLEADING INFORMATION IS AGAINST THE LAW AND COULD RESULT IN CRIMINAL PROSECUTION.

SIGNATURE  

TITLE  

DATE
### ANNUAL COMPETENCY EVALUATION DOCUMENTATION

**Required Training/Evaluation For Unlicensed Staff Providing or Supervising Care**

Trainee’s Name ___________________________ SS# __________________

LPN or RN Conducting Training/Evaluation ______________________________

<table>
<thead>
<tr>
<th>AREA EVALUATED</th>
<th>SATISFACTORY/UNSATISFACTORY</th>
<th>DATE</th>
<th>NURSE INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handwashing and basic infection control procedures</td>
<td></td>
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<tr>
<td>Assisting the resident with dressing</td>
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<tr>
<td>Assisting the resident with transferring</td>
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<td>Assisting the resident with ambulation</td>
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<td>Assisting the resident with bathing</td>
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<tr>
<td>Assisting the resident with personal grooming</td>
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<tr>
<td>Assisting the resident with toileting</td>
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<tr>
<td>Assisting the resident to eat</td>
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<td></td>
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<tr>
<td>Providing incontinence care</td>
<td></td>
<td></td>
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<tr>
<td>Providing a bed bath</td>
<td></td>
<td></td>
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<tr>
<td>Taking and recording vital signs</td>
<td></td>
<td></td>
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<tr>
<td>Addressing behavioral symptoms</td>
<td></td>
<td></td>
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<tr>
<td>Observing, recording and reporting tasks</td>
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<td></td>
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<tr>
<td>Identifying and reporting problems/changes</td>
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</table>

If additional training was required on any of the above components, document below the instruction provided and the date(s) retested.

______________________________________________________________________________

______________________________________________________________________________

Statement to Nurse Trainers

Staff training and evaluation must be completed prior to IPC service delivery and annually thereafter. It is the responsibility of the IPC facility to ensure that IPC resident aides and the supervising staff are competent to perform the tasks identified in the Service Care Plan of each IPC resident. The facility administrator and /or any staff person with daily supervisory responsibilities for the IPC resident aids must also be trained. Evidence of training/evaluation must be maintained in personnel records by the IPC service provider and made available to DHHS staff upon request. The training/evaluation for IPC is in addition to the annual training requirements for licensure by DHEC. For additional information, please call your regional DHHS IPC nurse.

Signature of RN or LPN ___________________________ Date ________________

DHHS Form 2503 (Jan 03)
INSTRUCTIONS: SCDHHS IPC Form 2503

ANNUAL COMPETENCY EVALUATION DOCUMENTATION

PURPOSE: This is a form to validate competency of staff in skills or tasks necessary for the provision of IPC services.

ITEM BY ITEM INSTRUCTIONS:

1. **Name of Personal Care Aide or Supervisor:** Enter name of trainee. All IPC aides and supervisors must be assessed as competent in tasks or skills that are necessary for providing IPC services.

2. **Area Evaluated:** All skills/tasks listed must be evaluated.

3. **S/U:** Indicate with an S for satisfactory performance or U for unsatisfactory performance for each task or skill evaluated. Any additional training or retesting should be indicated in the lined space provided below the Table.

4. **Date:** Enter date that skill or task was evaluated.

5. **Initials of Nurse:** RN or LPN that conducted evaluation enters her/his initials.

6. **Signature:** Full signature, and title (RN OR LPN) of nurse(s) conducting the evaluation signify that evaluation was completed in compliance with written Statement to Nurse Trainers.

SUBSTITUTION OF ANOTHER FORM: Another staff training or competency evaluation form can be used provided it was approved as part of the facility’s IPC Policies and Procedures.

FILING: This form should be retained at the facility with other staff training documents.
# Personnel Competency Evaluation Form

Name of Resident Assistant or Supervisor ____________________

<table>
<thead>
<tr>
<th>Skills or Tasks</th>
<th>S/U</th>
<th>Date</th>
<th>Initials of Nurse</th>
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</thead>
<tbody>
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</table>

S=Satisfactory Performance  
U=Unsatisfactory Performance

Place a full signature to correspond with each set of initials appearing above.

<table>
<thead>
<tr>
<th>Initials</th>
<th>Corresponding Signature of Nurse</th>
<th>Title</th>
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<tbody>
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</table>
INSTRUCTIONS: SCDHHS Form 2504
Personnel Competency Evaluation Documentation

PURPOSE: This is a form to validate competency of staff in skills or tasks necessary for the provision of IPC services. Tasks or skills not listed on the Annual Competency Evaluation Form that are necessary to deliver IPC or other services identified in the service care plan must be specified.

ITEM BY ITEM INSTRUCTIONS:
1. Name of Personal Care Aide or Supervisor: Enter name of trainee. All IPC aides and supervisors must be assessed as competent in tasks or skills that are necessary for providing IPC services
2. Area Evaluated: List skills/tasks to be evaluated.
3. S/U: Indicate with an S for satisfactory performance or U for unsatisfactory performance for each task or skill evaluated. Any additional training or retesting should be indicated in the lined space provided below the Table.
4. Date: Enter date that skill or task was evaluated.
5. Initials of Nurse: RN or LPN that conducted evaluation enters her/his initials.
6. Signature: Full signature, and title (RN OR LPN) of nurse(s) conducting the evaluation signify that evaluation was completed in compliance with written Statement to Nurse Trainers.

SUBSTITUTION OF ANOTHER FORM: Another staff training or competency evaluation form can be used provided it was approved via the IPC policies and procedures.

FILING: This form should be retained at the facility with other staff training documents.
IPC PROGRAM REFERRAL

RESIDENT NAME: ___________________________ ROOM#: ___________________________

CURRENT ADDRESS:

Street: ___________________________ State: ___________________________ Zip Code: ___________________________

City: ___________________________ County: ___________________________ Mailing Address: ___________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Phone#: ___________________________ Date of Birth: ___________________________

SS#: ___________________________ Medicare#: ___________________________

FACILITY INFORMATION

Facility Name: ___________________________ Provider ID#: ___________________________

Address: ___________________________ Phone#: ___________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

RESPONSIBLE PARTY INFORMATION

Name: ___________________________ Relationship: ___________________________

Address: ___________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Phone#: ___________________________ 2nd Phone#: ___________________________

RESIDENT STATISTICAL INFORMATION

Marital Status: ___________________________ Race: ___________________________

Sex: M ☐ F ☐

Primary Language: ENGLISH ☐ SPANISH ☐ OTHER ___________________________

RESIDENT DEFICIENCIES (CHECK)

LOCOMOTION ☐ DRESSING ☐ TOILET USE ☐ TRANSFER ☐

INCONTINENT ☐ EATING ☐ BATHING ☐

Cognitive Impairment/Diagnosis: ___________________________

Is Resident Aware of Referral: YES ☐ No ☐

If No, Please Explain: ___________________________

_________________________________________________________________________

Person Making this Referral: ___________________________ Phone#: ___________________________

PHYSICIAN INFORMATION

PRIMARY PHYSICIAN:

Address: ___________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Phone#: ___________________________
SOUTH CAROLINA INTEGRATED PERSONAL CARE PROGRAM

CONSENT FORM

Resident Name: __________________________________________________________

Social Security Number: _________________________________________________

I understand that as part of my application for services in a participating Integrated Personal Care Facility, my condition must be evaluated by the South Carolina Integrated Personal Care Program.

This evaluation includes information provided by:

a. my physician and medical records;

b. professionals, organizations and facility staff members 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 the South Carolina Integrated Personal Care Program any medical information regarding my diagnosis, functional abilities and recommended treatment.

I hereby authorize the South Carolina Integrated Personal Care Program to release information on my behalf to the following: physicians, hospitals, health and human service organizations, health and human service agencies, family members, the residential care facility and/or other persons directly involved with my care.

I understand that 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 that I or my responsible party may be contacted for additional information. Also, if an extraordinary situation should arise, I understand that photographs may be taken and used to document suspected problems.

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 for one year from the date the consent is signed or until revoked by me in writing, or until such time as my case is closed by the Integrated Personal Care Program.

________________________________________
Date                                                   Signature of Client or Responsible Party

If signed by Responsible Party, state relationship and authority to do so

________________________________________
Date                                                   Signature of Witness

DHHS Form 2502 (Revised Jan 03)
## IPC Service Care Plan Elements

<table>
<thead>
<tr>
<th>Date &amp; Sign</th>
<th>Problem</th>
<th>Goal/Objective</th>
<th>Target Date</th>
<th>Tasks</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
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DHHS FORM CRCF-01 (JAN 03)
INSTRUCTIONS: DHHS IPC Service Care Plan Elements

PURPOSE: This form contains the elements that are to be incorporated into the individualized service care planning document on each IPC resident which directs the provision of personal care. The plan is developed and signed by a registered nurse.

ITEM BY ITEM INSTRUCTIONS:
1. Facility Name: Enter the name of the CRCF.
2. Resident: Enter the name of the resident.
3. Medicaid ID #: Enter the Medicaid identification number of the resident.
4. Date and Sign: Enter the date when the plan is developed and provided signature.
5. Problem: Clearly defined, addressing dependencies/impairments identified on the SCDHHS Form 1718.
6. Goal: A positive, measurable statement of what is to be achieved.
7. Target Date: Date for expected resolution of the problem.
8. Tasks: Enter tasks that may be assigned to IPC facility aides.
9. Date Achieved: Enter the date when the registered nurse evaluates whether or not the problem was resolved.

NOTE:
1. Service Care Plan practices shall be in compliance with Individual Care Plan Standards set forth in Section 703 of the DHEC Standards for Licensing Community Residential Care Facilities, Regulation Number 61-84.

2. Dependencies or impairments identified in the IPC assessment must be addressed in the service care plan.

REVISIONS: The service care plan must be revised by the registered nurse at least every six months and more frequently if changes in the resident’s condition necessitate a change in the plan of care.

SUBSTITUTION OF ANOTHER FORM: The Service Care Plan elements can be incorporated into an existing care plan format.

FILING: The service care plan must be maintained in the permanent record of the resident and be available to all staff that provide care to the residents. The initial service care plan should be faxed/mailed to the regional DHHS nurse for approval. Subsequent service care plans will be reviewed by the DHHS nurse on site visits.
## Service Care Plan

<table>
<thead>
<tr>
<th>Date &amp; Sign</th>
<th>Problem</th>
<th>Goal/Objective</th>
<th>Target Date</th>
<th>Tasks</th>
<th>Date Achieve</th>
</tr>
</thead>
</table>
| 6/19/02     | 1) Incontinence of urine during sleeping hours | Be continent at all times. | 8/19/02 | 1) No fluids after 8 PM  
2) Assist to bathroom just before bedtime  
3) Awaken at 6AM. and assist to bathroom.  
3) Record incontinence on daily log  
4) Avoid using adult pads/briefs  
5) Offer to assist to toilet every 2 hours during awake hours | | |
| 6/19/02     | 2) Lack of interest in daily activities | 1) Demonstrate an increased interest in self-care activities by getting up in the morning without being prompted more than once. | 8/19/02 | 1) Assist in laying out clothing the night before.  
2) Before bedtime talk with resident about the next day’s activities  
3) List things the resident says they enjoy doing  
4) Attempt to have meaningful activities for the resident to engage in. | | |
# Integrated Personal Care Service Provision Form

**PROVIDER:** VERIFY
**MEDICAID ELIGIBILITY MONTHLY**

**TYPE OF AUTHORIZATION:** New

**From:**
IPC Program  
P.O.Box 8206  
7th Floor Suite  
Columbia, SC  29202-8206

**AUTHORIZATION IS HEREBY GIVEN TO PROVIDE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.**

<table>
<thead>
<tr>
<th>Service(s) Authorized: IPC Waiver Services</th>
<th>IPC PROCEDURE CODE:</th>
</tr>
</thead>
</table>

**Authorized Start Date:**  
**Authorized End Date:** (if applicable)

**Comments:**

**Total Units Authorized:** 7  
Sun 1  
Mon 1  
Tue 1  
Wed 1  
Thur 1  
Fri 1  
Sat 1

## CLIENT INFORMATION

<table>
<thead>
<tr>
<th>NAME</th>
<th>BIRTHDATE</th>
<th>SEX</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE NO.</th>
<th>IPC CLIENT NO.</th>
<th>SOCIAL SEC NO.</th>
<th>MEDICAID NO.</th>
<th>ELIGIBILITY TYPE</th>
</tr>
</thead>
</table>

## RESPONSIBLE PARTY

<table>
<thead>
<tr>
<th>NAME</th>
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<tr>
<th>ADDRESS</th>
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<thead>
<tr>
<th>RELATIONSHIP</th>
<th>HOME TELEPHONE</th>
<th>WORK TELEPHONE</th>
</tr>
</thead>
</table>

**Physician:**  
**Directions to client’s home:**

---

**Case Manager’s Signature:**  
**Date:**

**Sent:**  
**Date:**  
**Initials:**

**☐ PROVIDER  ☐ BILLING CLERK  ☐ FILE**

SCDHHS FORM 175  JUL 92
### TASK

- **DIET**
  - G-good 75%
  - F-fair 50%
  - P-poor 25%
  - R-refused

- **BATHING**
  - S-shower
  - T-tub
  - P-partial

- **DRESSING**
  - S
  - A
  - T

- **LOCOMOTION**
  - W-walks
  - WA-walker
  - WC-wheelchair
  - C-cane

- **TRANSFER**
  - S
  - A
  - T

- **TOILETING**
  - T-toileting program
  - D-pads or briefs

- **BLADDER**
  - C-continent
  - I-incontinent

- **BOWEL**
  - C-continent
  - I-Incontinent

- **BEHAVIOR**
  - Weight Monitor
  - Vital Signs Monitor

### DAILY TASK LOG

| HOUR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

### WEEKLY MONITOR NURSE SIGNATURE/DATE

<table>
<thead>
<tr>
<th>RESIDENT’S NAME</th>
<th>ROOM/BED NUMBER</th>
<th>MEDICAID NUMBER</th>
</tr>
</thead>
</table>

---

Division of Community and Facility Services

Integrated Personal Care Program

---
INSTRUCTIONS: SCDHHS IPC FORM 2507
DAILY TASK LOG
PURPOSE: This is a form to indicate the amount of assistance a resident is requiring on a daily basis that is kept for the entire month.

ITEM BY ITEM INSTRUCTIONS:

At the top:

1. Month/year: Enter the current month and the current year that these activities are taking place.
2. Diet: Enter for each day of the month, the letter for the amount of food consumed for each meal and check the amount of assistance that was required for them to eat.
3. Bathing: Enter the type of bath the resident required and check the level of assistance needed.
4. Dressing: Enter the amount of assistance given.
5. Locomotion: Enter how the resident locomotors and check the amount of assistance given to complete this activity.
6. Transfer: Enter/check the amount of assistance given.
7. Toileting: Enter if the resident receives a toileting program or uses pads/briefs.
8. Bladder: Enter whether the resident is continent or incontinent for each day, then check the amount of assistance given to the resident for cleanup.
9. Bowel: Enter whether the resident is continent or incontinent, then check the amount of assistance that is given for cleanup.
10. Behavior: Enter the daily resident’s behavior.
11. Weight: Enter how often the weight is monitored, then place the weight in the appropriate days box.
12. Vital Signs: Enter/check which vital sign is taken and how often by “Monitor” then place the vital sign recording in the appropriate days block.
13. Aide’s Initials: Enter the initials of the aide providing majority of personal care each day.

At the bottom:

14. Weekly Monitor Nurse Signature/Date: The licensed nurse will sign and date the weekly review for completion of the form.
15. Resident’s Name: Enter the name of the resident that the log is being kept for.
16. Room/Bed Number: Enter which room and bed the resident is in.
17. Medicaid Number: Enter the resident’s Medicaid identification number.
18. Name of CRCF: Enter the name of the facility.
19. Provider Number: Enter the facility’s Medicaid provider number.

Back of Form, Top Section:

20. Initial/Signature: Any aide documenting on the form must place initials and corresponding signature in this Section.

SUBSTITUTION OF ANOTHER FORM: Another Personal Care Log or Record can be used provided that there is a record initialed daily by the aide assisting the resident with Activities of Daily Living and that a licensed nurse must record monitoring for completeness weekly.

FILING: This record is to be maintained in each resident’s chart for the period of time as required by DHEC Regulation 61-84.
## Daily Census Log

| OSS or IPC | H | W/C | Last, First Name of Resident----- | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |

**Codes**
- I = IPC Participant
- O = OSS only
- W/C = wheelchair
- H = hospice client
- NH = Transferred to nursing home
- RC = Transferred to CRCF
- DHHS FORM 2502 (revised JULY 2007)

**Codes for Calendar**
- A = Admitted
- E = Expired
- D = Discharged
- X = Other (specify at bottom)

This is to certify that this is a correct daily census of all residents for
the month/year of _________________________________.

Signature/ Facility Administrator/Designee

Date

THIS IS A TWO-SIDED FORM
INSTRUCTIONS: SCDHHS IPC FORM: DAILY CENSUS LOG

PURPOSE: This is a form to indicate on a daily basis the location and type of residents at the CRCF.

ITEM BY ITEM INSTRUCTIONS:
1. Name of Facility: Enter the name of the CRCF.
2. Provider ID Number: Enter the assigned OSS Provider number.
3. Month and Year: Enter the month and year of the reporting period.
4. OSS or IPC: For a resident enrolled in the IPC Program enter an “I”; for residents only receiving OSS enter an “O”. If not in IPC or OSS, leave blank.
5. W/C or hospice: For a resident that has used a wheelchair during the month, enter a w/c in the block preceding the resident’s name. For a resident that has enrolled in a Hospice Care program, enter an H.
6. Name of Resident: Enter the names of all residents at the CRCF during the month of the reporting period.
7. Calendar Days 1 – 31: Using the “Codes for Calendar” at the bottom of the form, leave date blank for residents at the CRCF and use the other designated abbreviations as indicated.
8. Signature and Date: The facility administrator or designee dated signature certifies the correctness of the form.

SUBSTITUTION OF ANOTHER FORM: Another daily census form or monthly roster of residents can be used in place of this form provided the substituted form can be altered to provide the information requested.

FILING/SUBMISSION OF FORM: The original of this form should be maintained at the CRCF; a copy should be mailed/faxed to the IPC Central Office by the 10th of the following month. Address and Fax are as follows:

IPC Program
Attention: IPC Program Assistant
SC Dept of Health & Human Services
PO Box 8206
Columbia, SC  29202-8206
FAX: (803) 255-8209
INTEGRATED PERSONAL CARE NOTIFICATION FORM

TO: 
FROM:
IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206
(803)898-2590

Client: 
SSN#: 
MA#: 

• Comments: Comments in this section would relate to specific resident status in the IPC Program.

IPC Signature: ___________________________ Date: __________________

COPIES SENT TO:

[ ] Client
[ ] LTC Facility
[ ] County DSS
[ ] Caregiver/Responsible Party

[ ] Hospital
[ ] Physician
[ ] Other
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OPTIONAL STATE SUPPLEMENTATION & INTEGRATED PERSONAL CARE PROGRAMS
NOTICE OF ADMISSION, AUTHORIZATION & CHANGE OF STATUS FOR COMMUNITY RESIDENTIAL CARE FACILITY

SECTION I – IDENTIFICATION OF PROVIDER AND RESIDENT

<table>
<thead>
<tr>
<th>1. RESIDENTS NAME (FIRST, M. INITIAL, LAST)</th>
<th>2. BIRTH DATE</th>
<th>3. RESIDENTS MEDICAID I.D. NUMBER</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

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<thead>
<tr>
<th>4. RESIDENTS ADDRESS</th>
<th>5. COUNTY NAME</th>
<th>6. SOCIAL SECURITY NO.</th>
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<tbody>
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</table>

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<thead>
<tr>
<th>7. CRCFS NAME &amp; ADDRESS (ST. NAME, CITY, STATE)</th>
<th>8. CRCFS I.D. #</th>
<th>9. DATE OF REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

SECTION II – ADMISSION, INCOME, TRANSFER, TERMINATION OR CHANGE IN STATUS

* (A) ADMITTED TO THIS CRCF ON ________________________________

* (B) AUTHORIZATION TO BEGIN PAYMENT ________________________________

* (C) RESIDENTS COUNTABLE INCOME EFFECTIVE: ________________________________

* (D) TRANSFERRED TO ANOTHER CRCF ________________________________

* (E) TERMINATION/DISCHARGE ________________________________ IF DECEASED, SPECIFY DATE OF DEATH ________________________________

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS ________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

*REMEMINDER: DATE OF ADMISSION IS BILLED, DATE OF DISCHARGE IS NOT

SECTION III – ABSENCES

* (A) ADMITTED TO A NURSING FACILITY ________________________________

* (B) ADMITTED TO A MEDICAL INSTITUTION OR MENTAL HEALTH FACILITY ________________________________

* (C) READMITTED FROM A MEDICAL INSTITUTION, MENTAL HEALTH FACILITY OR NURSING FACILITY ________________________________

* (D) TEMPORARY MEDICAL ABSENCE – BEGINNING ________________________________ ENDING ________________________________

* (E) TEMPORARY NON-MEDICAL ABSENCES – BEGINNING ________________________________ ENDING ________________________________

AUTHORIZED ELIGIBILITY WORKER SIGNATURE ________________________________ DATE ________________________________

AUTHORIZED COMMUNITY RESIDENTIAL CARE FACILITY SIGNATURE ________________________________ DATE ________________________________
Integrated Personal Care
Service Termination Notice

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

From: IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206

AUTHORIZATION IS HEREBY GIVEN TO TERMINATE THE FOLLOWING SERVICE(S)
UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND
HUMAN SERVICES FOR THE PROVISION THEREOF.

Service(s) Authorized:________________________________________ IPC PROCEDURE
Authorized Start Date:________________________ Authorized End Date:________________________
Authorized End Date: (if applicable)

Reason for Termination:

Total Units Authorized: 7 Sun 1 Mon 1 Tue 1 Wed 1 Thu 1 Fri 1 Sat 1

CLIENT INFORMATION

<table>
<thead>
<tr>
<th>NAME</th>
<th>BIRTHDATE</th>
<th>SEX</th>
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ADDRESS

Aiken, SC 29803

TELEPHONE NO.  IPC CLIENT NO.  SOCIAL SEC NO.  MEDICAID NO.  ELIGIBILITY TYPE

RESPONSIBLE PARTY

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Physician:

Directions to client’s home:

________________________________________________________

Case Manager’s Signature: __________________________ Date: ____________

Sent: ________ Date: ________ Initials: __________

☐ PROVIDER  ☐ BILLING CLERK  ☐ FILE

SCDHHS FORM 175-B  JUL 94