FORMS

Number	Name	Revision Date
DHHS 931	Health Insurance Information Referral Form	01/2008
	Authorization Agreement For Electronic Funds Transfer	03/2011
	Duplicate Remittance Advice Request Form	10/2012
	Sample Remittance Advice	
	Sample Turn Around Document	
DHHS 2503	Annual Competency Evaluation Documentation (two pages)	01/2003
DHHS 2504	IPC Personnel Competency Evaluation Form (two pages)	01/2003
DHHS 2501	IPC Program Referral	11/2003
DHHS 2502	Consent Form	01/2003
DHHS 2505	IPC Service Care Plan Elements (two pages)	01/2003
DHHS 2500	Sample Service Care Plan	01/2003
DHHS 175	IPC Service Provision Form	07/1992
DHHS 2507	Daily Task Log (two pages)	01/2003
DHHS 2506	Daily Census Log (two pages)	07/2007
	IPC Notification Form	
CRCF-01	Notice of Admission, Authorization & Change of Community Residential Care Facility	01/2003
DHHS 175-B	IPC Service Termination Notice	07/1994

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:	**or**	**Mail:**
803-252-0870		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:	**or**	**Mail:**
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

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 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**

NHM4530R03
RUN DATE 12/09/2002 (1)

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY RESIDENTIAL CARE
OPTIONAL STATE SUPPLEMENTATION REMITTANCE ADVICE

CRCF NO. RC0XXX (2)

CHECK DATE:12/13/02 (3)
CHECK NUMBER:2999994 (4)
CHECK AMOUNT:$000.00 (5)

BANK NAME: (6)
BANK NUMBER: (7)
ACCOUNT NUMBER: (8)

LINE	(9) RECIPIENT NAME		(10) RECIPIENT ID NO	(11) DATE OF SERVICE	(12) CRCF DAYS	(13) INCOME	(14) OSS/IPC PAYMENT	(15) STATUS CODE	(16) EDIT CODE	(17) CLAIM CONTROL NUMBER
01	GERALDINE	ALSTON	2889990001	11/01/02	10	$000.00	$0.00	8 P	, ,	0233199999130000G
01							$000.00			
02										
02										
03										
04										
05										
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18										
19										
20										

REPORT NH4545R1 SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 1
DATE 12/16/2002 COMMUNITY RESIDENTIAL CARE
FOR MONTH OF FEBRUARY

(1) CRCF NO. RC0999 HAPPY HOME (2)
111 VALLEY ST
LEXINGTON SC 29687

					(8)			ENTER CHANGES		
(3)	(4)	(5)	(6)	(7)	DATE OF	(9)	(10)	(11)	(12)	(14)
LINE	COUNTY	RECIPIENT NAME	RECIPIENT ID NO	MONTHLY INCOME	SERVICE MO/YR	CRCF DAYS	IPC DAYS //	CHANGED CRCF DAYS	CHANGED IPC DAYS	DELETE FROM NEXT MONTH'S TA
01	32	MARY SMITH	1234567801		02/03	28				
02	32	SAM PERKINS	9876543201		02/03		28			
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										
16										
17										

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 SCDHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCF 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 CRCF 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 TAD'.

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 _____

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

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.

Integrated Personal Care (IPC)
Personnel Competency Evaluation Form

Name of Resident Assistant or Supervisor _____

---------- Skills or Tasks ----------	----S/U ----	-- ---Date-----	Initials of Nurse

S=Satisfactory Performance
U=Unsatisfactory Performance

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

Initials	Corresponding Signature of Nurse	Title

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:		
City:	**State:**	**Zip Code:**
County:		
Mailing Address:		
City:	**State:**	**Zip Code:**
Phone#: ( )	**Date of Birth:**	
SS#:	**Medicare#:**	
Medicaid#:		

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#: ( )

FAX THIS COMPLETED FORM AND SIGNED CONSENT TO: (803) 255-8209

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)

Facility _____

Resident _____

Medicaid ID #_____

IPC Service Care Plan Elements

Date & Sign	Problem	Goal/Objective	Target Date	Tasks	Date Achieved

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

Facility _____

Resident _____

Date & Sign	Problem	Goal/Objective	Target Date	Tasks	Date Achieve
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.

Service(s) Authorized: IPC Waiver Services

IPC PROCEDURE CODE: _____

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

NAME			BIRTHDATE	SEX
ADDRESS				
TELEPHONE NO.	IPC CLIENT NO.	SOCIAL SEC NO.	MEDICAID NO.	ELIGIBILITY TYPE

RESPONSIBLE PARTY

NAME		
ADDRESS		
RELATIONSHIP	HOME TELEPHONE	WORK TELEPHONE

Physician: _____

Directions to client's home:

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

SCDHHS FORM 175 JUL 92

Division of Community and Facility Services
Integrated Personal Care Program

DAILY TASK LOG

Month/Year _____

TASK	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
DIET ☐ G-good 75% F-fair 50% P-poor 25% R-refused S_____ A_____ T_____	Break Lunch Dinner Snack																															
BATHING ☐ S-shower T-tub P-partial S_____ A _____ T _____																																
DRESSING ☐ S _____ A _____ T _____																																
LOCOMOTION ☐ W-walks WA-walker WC-wheelchair C-cane S _____ A _____ T _____																																
TRANSFER ☐ S _____ A _____ T _____																																
TOILETING ☐ T-toileting program D-pads or briefs S _____ A _____ T _____																																
BLADDER ☐ C-continent I-incontinent S _____ A _____ T _____																																
BOWEL ☐ C-continent I-Incontinent S _____ A _____ T _____																																
BEHAVIOR ☐																																
Weight ☐ Monitor _____																																
Vital Signs ☐ Monitor _____Blood Pressure _____ Temperature _____ Pulse _____ Respirations																																
AIDE'S INITIALS																																
WEEKLY MONITOR NURSE SIGNATURE/DATE																																

RESIDENT'S NAME	**ROOM/BED NUMBER**	**MEDICAID NUMBER**

Initials	Signature	Initials	Signature

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.

DIVISION OF COMMUNITY AND FACILITY SERVICES
Optional State Supplementation
Integrated Personal Care Program

DAILY CENSUS LOG

Name of Facility	Provider ID No.	Month/Year

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

DHHS FORM 2502 (revised JULY 2007)
THIS IS A TWO-SIDED FORM

Codes for Calendar
A = Admitted
E= Expired
D = Discharged
RC = Transferred to CRCF
NH = Transferred to nursing home
X = Other (specify at bottom)
H = Transferred home
PL = Personal Leave
HL = Hospital Leave

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

_____)knalb(tneseroP =
Signature/ Facility Administrator/Designee Date

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 1 – IDENTIFICATION OF PROVIDER AND RESIDENT

1. RESIDENTS NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE _____ | _____ | ____ (MO.) (DAY) (YR.)	2. RESIDENTS MEDICAID I.D. NUMBER __ __ __ __ __ __ __ __ __ __
4. RESIDENTS ADDRESS	5. COUNTY NAME	6. SOCIAL SECURITY NO. __ __ __ |__ __ | __ __ __ __
7. CRCFS NAME & ADDRESS (ST. NAME, CITY, STATE)	8. CRCFS I.D. #	9. DATE OF REQUEST __ __ | __ __ | __ __ (MO.) (DAY) (YR.)

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

* (A) ADMITTED TO THIS CRCF ON _____
(MO.) (DAY) (YR.)

(B) AUTHORIZATION TO BEGIN PAYMENT _____
(MO.) (DAY) (YR.)

(C) RESIDENTS COUNTABLE INCOME EFFECTIVE: _____ $ _____ $_____
(MO.) (YR.) AMOUNT PERSONAL NEEDS AMOUNT

(D) TRANSFERRED TO ANOTHER CRCF _____ _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY COUNTY

* (E) TERMINATION/DISCHARGE _____ IF DECEASED, SPECIFY DATE OF DEATH _____
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

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

_____

_____

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

SECTION III – ABSENCES

(A) ADMITTED TO A NURSING FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(B) ADMITTED TO A MEDICAL INSTITUTION OR MENTAL HEALTH FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(C) READMITTED FROM A MEDICAL INSTITUTION, MENTAL HEALTH FACILITY OR NURSING FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(D) TEMPORARY MEDICAL ABSENCE – BEGINNING _____ ENDING_____
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

(E) TEMPORARY NON-MEDICAL ABSENCES – BEGINNING _____ ENDING _____
(MO). (DAY) (YR.) (MO). (DAY) (YR.)

_____ _____
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 CODE: _____

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

Reason for Termination: _____

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

CLIENT INFORMATION

NAME		BIRTHDATE	SEX
ADDRESS	AIKEN, SC 29803		
TELEPHONE NO.	IPC CLIENT NO.	SOCIAL SEC NO.	MEDICAID NO.	ELIGIBILITY TYPE

RESPONSIBLE PARTY

NAME		
ADDRESS		
RELATIONSHIP	HOME TELEPHONE	WORK TELEPHONE

Physician: _____

Directions to client's home:

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

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