Healthy Connections

South Carolina Department of Health and Human Services

OSS Slot Reservation Request Notice of Admission, Authorization, & Change of Status for Community Residential Care Facility

things to know

General Information

DHHS FORM CRCF-01 is utilized by Community Residential Care Facilities and/or SCDHHS Medicaid Eligibility Workers. The DHHS CRCF 01 is authorization by the Department of Health and Human Services for payment and reimbursement for OSS services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider services. **The form must be completed electronically. Handwritten forms will not be accepted.**

Detailed Instructions

Reason for Submission: Identify the reason for submission (Initial, Status Change, Termination)

A. Section I – Identification of Provider and Patient

This section will be completed in its entirety by the originating party. The provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider number.**

B. Section II – Will be completed by the OSS CTLC office.

C. Section III - Type of Coverage and Statistical Data

The provider of services and/or the SC DHHS Medicaid Eligibility worker may initiate this section. The section is used to show the transfers/ readmissions from other facilities or hospitals, termination, and medical/ non-medical bed holds.

D. Section IV – Authorization and Change of Status

Only the SC DHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SC DHHS Medicaid Eligibility Approval Authority /Supervisor of a SC DHHS Authorized Representative must sign and date each form for all new admissions, income change, and discharges that affect income liability.

Distribution, Preparation and Routing of Form

The Provider of Services will normally initiate these forms. The SC DHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The provider of services must forward the forms to the appropriate SC DHHS Medicaid Eligibility Worker only when signature authorization in Section IV is required. Send to SCDHHS - Central Mail, P.O. Box 100101, Columbia, SC 29202.

A.

Copy	Submitted by Provider for claims processing MCCS
Copy	Retained and kept on file by SC DHHS Medicaid Eligibility
Original	Retained and kept on file by the Provider of Services

B. The Provider of Services must attach a copy of this form to the current month's billing for each change in the status of a patient. Send all CRCF-01 forms together for each patient. Mailing address for 18th of month claims:

Claims Receipt- CRCF
Claims Section
Post Office Box 67
Columbia, SC 29202-0067

Healthy Connections

South Carolina Department of Health and Human Services

Optional State Supplementation (OSS) Slot Reservation Request Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

RESET FORM

Reason for Submission: Choose One

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident's Name (First, Middle, Last)	2.Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits)
4. CRCF Name	6.County of Residence	7. Social Security No.
5. CRCF Street Address	8. CRCF Provider ID# R C	9. Date of Request
City / State / ZIP		
10. Authorized Representative's Name	12. Authorized Representative's Street Address	
11. Authorized Representative's Phone No.	City / State / ZIP	

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: CRCF Transfer Date:

Name of new CRCF or institution:

(B) Terminated/Discharged because no longer financially eligible Termination Date:

Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds Medical Absence

Start Date _____ End Date _____

Start Date _____ End Date _____

Start Date _____ End Date _____

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

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)

1. Application Date _____ MO-DD-YYYY

2. Medicaid Status

☐ Denied: Incomplete app.

☐ SSI Recipient

☐ Financially Ineligible

☐ Financially eligible awaiting OSS slot authorization

(A) Authorization to Begin Payment _____ MO-DD-YYYY

(B) Resident's Countable Income Effective _____ MO-YYYY $ _____ Personal Needs Amount $ _____

Section V – Signature

_____

Eligibility Worker Name (Print)

_____ _____

Authorized Eligibility Worker Signature Date