

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	EFT Authorization Agreement	03/2011
	Duplicate Remittance Advice Request Form	10/2012
	Sample Remittance Advice	
	Sample Turn Around Document (TAD)	
CRCF-01	Notice of Admission, Authorization & Change of Status for Community Residential Care Facility	01/2013
CRCF-02	Communication Form	
	SSI Recipient Request for Optional State Supplementation	
	Annual Competency Evaluation Documentation	
	Potential In-Service Topic List	
	Resident Weekly Care Log	
	Consent Form	
	Community Residential Care Facility Accessibility Checklist (six pages)	



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



**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

**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

REPORT NH4545R1
DATE 06/25/2013

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY RESIDENTIAL CARE
FOR MONTH OF JUNE

PAGE 1

CRCF NO. RC0099 Happy Home
111 Valley St
Lexington

SC 29687

E N T E R C H A N G E S

LINE	COUNTY	RECIPIENT NAME	RECIPIENT ID NO	MONTHLY INCOME	DATE OF SERVICE MO/YR	CRCF DAYS	OSCAP DAYS	CHANGED CRCF DAYS	CHANGED OSCAP DAYS	DELETE FROM NEXT MONTH'S TAD
01		Mary Smith	1234567801		02/03	28				
02		Sam Perkins	9786543201		02/03		28			
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										

- 13
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 JUNE, 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 JUNE, 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.

South Carolina Department of Health and Human Services
Optional State Supplementation (OSS) Slot Reservation Request & Integrated Personal Care Programs
Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

Section I. Identification of Applicant/Resident (Completed by SCDHHS or CRCF Staff)			
1. Applicant/ Resident's Name		2. Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits) <div style="border: 1px solid black; width: 100%; height: 20px; display: flex; justify-content: space-between;"> </div>
4. Applicant/Resident's Address		5. County of Residence	6. Social Security No. <div style="border: 1px solid black; width: 100%; height: 20px; display: flex; justify-content: space-between;"> </div>
7. CRCF Name Address		8. CRCF Provider ID# R C <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-between;"> </div>	9. Date of Request
10. Authorized Representative's Name and Address			Telephone No.
11. Application Date	12. Date Entered CRCF	13. Medicaid Status <input type="checkbox"/> SSI Recipient <input type="checkbox"/> Financially eligible awaiting OSS slot authorization	14. Adult Services Priority <input type="checkbox"/> YES <input type="checkbox"/> NO
Medicaid Worker Name:			Date:
Section II – Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)			
1. Date Applicant Entered CRCF	2. Effective Date of Slot	3. Name of CRCF	4. <input type="checkbox"/> Check if applicant did not enter CRCF
CLTC Worker's Name:			Date:
Section III – Admission, Income, Transfer, Termination or Change Status (Completed by SCDHHS or CRCF staff. Signature required in Section V)			
(A) Authorization to Begin Payment _____ <div style="text-align: center; font-size: small;">MO-DY-YY</div>			
(B) Resident's Countable Income Effective _____ \$ _____ Personal Needs Amount \$ _____ <div style="text-align: center; font-size: small;">MO-YY</div>			
(C) Transferred to another CRCF _____ Name of CRCF _____ County _____ <div style="text-align: center; font-size: small;">MO-DY-YY</div>			
(D) Termination Date/Discharge Date _____ If Deceased, Specify Date of Death _____ <div style="text-align: center; font-size: small;">MO-DY-YY MO-DY-YY</div>			
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 IV – Absences (Completed by the CRCF. Signature required in Section V)			
(A) Date admitted to Nursing Facility _____ Name of Facility _____ <div style="text-align: center; font-size: small;">MO-DY-YY</div>			
(B) Date Admitted to a Medical Institution _____ Name of Facility _____ Or Mental Health Facility <div style="text-align: center; font-size: small;">MO-DY-YY</div>			
(C) Date Readmitted from a Medical Institution _____ Name of Facility _____ Or Nursing or Mental Health Facility <div style="text-align: center; font-size: small;">MO-DY-YY</div>			
(D) Temporary Medical Absence – Beginning Dated _____ Ending Date _____ <div style="text-align: center; font-size: small;">MO-DY-YY MO-DY-YY</div>			
(E) Temporary Non-Medical Absence – Beginning Dated _____ Ending Date _____ <div style="text-align: center; font-size: small;">MO-DY-YY MO-DY-YY</div>			
Section V – Signature (Required only when completing Section III or Section IV)			
_____ Authorized Eligibility Worker Signature		_____ Date	
_____ Authorized Community Residential Care Facility Signature		_____ Date	



State of South Carolina
Department of Health and Human Services

Iim Hodges
Governor

12/11/02

William A. Prino
Director

Dear

RE: 0412723

An Optional State Supplement (OSS) slot is now available for you.

As of the above date, you may select a licensed community residential care facility (CRCF) that participates in the OSS program. Please take this notification to the CRCF you select. This letter is valid for 30 calendar days from the date of the letter. If you are not admitted by 1/10/03, you must reapply for OSS at your DSS County Office. The CRCF must complete the bottom portion of this form on the day you are admitted and return it to the Community Long Term Care office listed below.

Signature and Date of CLTC Staff: _____

SECTION II

TO BE COMPLETED BY A LICENSED COMMUNITY RESIDENTIAL CARE FACILITY ENROLLED IN THE OSS PROGRAM:

INSTRUCTIONS FOR CRCF: Complete and return this form to the following CLTC area office:

Community Long Term Care
1890 Neely's Creek Road

Rock Hill, SC 29730

Please note that a delay in return of this form, incorrect information or blanks in Section II shall result in a delay of the OSS Payment to your facility.

CRCF name: _____

CRCF provider number: _____

Date resident entered facility: _____

Date completed: _____

Signature and title of CRCF official: _____

SSI Recipient Request for Optional State Supplementation (OSS)

1. I, _____, am currently eligible for supplemental Security Income (SSI).
2. I live or plan to live in a Community Residential Care Facility (CRCF).
3. I need help with paying the cost of living in a CRCF.
4. I request this help through the Optional State Supplementation (OSS) program.

The following statements explain your rights and responsibilities. If there are statements you do not understand, you should discuss those statements with the worker during the interview. You are responsible for giving complete and accurate information.

I understand that I must report any and all changes in my income, living arrangements, or other information that will affect my eligibility for OSS within 10 days of the date of the change(s).

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under State/Federal laws.

I understand that any information I have given is subject to being reviewed by staff members of the Department of Social Services and the Department of Health and Human Services. Also, I understand that I must cooperate fully with State and Federal workers if my case is selected for a complete review.

I understand that is request will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

I understand that I may request a hearing if I am not satisfied with the actions taken on my case or if I feel that I have been discriminated against.

I certify that I have read or had read to me all the statements on this form and the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department(s) permission to verify, without additional consent from me, information discovered by the Department(s) or given by me that is needed to determine my eligibility for OSS.

Signature _____ Date _____

Applicant/Responsible Party

Applicant's SSN _____ Telephone Number _____

Applicant's Address _____
(Name of facility _____
if already residing _____
in CRCF) _____

Worker's Signature _____ Date _____

ANNUAL COMPETENCY EVALUATION DOCUMENTATION

REQUIRED TRAINING/COMPETENCY EVALUATION FOR UNLICENSED STAFF PROVIDING OR SUPERVISING CARE

Staff Name: _____ SS#: _____

Position: _____ LPN/RN Conducting Training/Evaluation: _____

Competency Area	Competency Level	Date	Nurse Initials
Hand washing and basic infection control procedures	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with dressing	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with dressing having weak/affected arm	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with transferring	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with ambulation	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with a wheelchair and wheelchair safety	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with bathing	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with personal grooming	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting with mouth care and cleaning of dentures	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with toileting	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Assisting the resident with eating	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Providing continence care	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Providing a bed bath	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Taking and recording vital signs	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Addressing behavioral symptoms	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Observing, recording and reporting tasks	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Identifying and reporting problems/changes	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
Applying T.E.D. Hose	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		

The competency evaluation must be completed by all staff prior to providing direct care to OSCAP participants and annually thereafter. It is the responsibility of the OSCAP provider to ensure all resident assistants and supervising staff are competent to perform the tasks identified in each resident's individual care plan. The facility administrator and/or any staff person with daily supervisory responsibilities for the resident assistants must complete the training necessary for the competency evaluation. Evidence of training/competency must be maintained in the personnel records by the OSCAP provider, and be available to a SCDDHS representative upon request. The training and competency evaluation for OSCAP is in addition to DHEC training requirements for licensure.

LPN Signature: _____ Date: _____

RN Signature: _____ Date: _____

POTENTIAL IN-SERVICE TOPIC LIST

OPTIONAL SUPPLEMENTATION FOR ASSISTED LIVING PARTICIPANTS (OSCAP)

All about Headaches

Assistive Devices

Bathing Tips

Being Assertive

Building Trust & Confidence with Residents

Common Diets

Communication Skills

Cultural Diversity

Customer Service Care

Dealing with Dizziness

Dealing with Family Members

Documentation of Direct Care and Record Keeping

Documenting Physical and Mental Changes

Ergonomics/Body Mechanics

Feeding Your Clients

Flu Season

Getting Off to a Good Start with a Resident

Hand washing

Hearing and Disorders

Heart Attacks and Strokes

Heart Failure

HIPAA

How to Prioritize Your Work

Maintaining a Professional Distance

Maintaining Client's Dignity

Men's Health Issues

Mouth Care

Non-Compliant Clients

Non-Traumatic Emergencies

Normal Aging Process

Nutrition and Hydration

Overview of the Body

Pain and the Elderly

Parkinson's Disease

Performing Safe Transfers

Personal Care Safety Issues

Personal Hygiene

Preventing Pressure Sores

Professionalism and Work Ethics

Safety in the Workplace

Skin Care

Stress Management

Techniques for Giving Bed Baths

Toileting Tips

Understanding Alzheimer's Disease & Other Dementias

Understanding Basic Human Needs

Understanding Depression

Understanding Diabetes

Understanding Hypertension Activity and the Elderly

Women's Health Issues

Working with a Person with a Mental Illness

Working with a Person with an Intellectual or Developmental Disability

Working with Difficult & Combative People

Resident Weekly Care Log

____ / ____ / ____
Week of

	ACTIVITIES	LEVEL	SUN	MON	TUE	WED	THU	FRI	SAT
Transfer	<input type="checkbox"/> Lifted manually/mechanically								
	<input type="checkbox"/> Transfer aid								
	<input type="checkbox"/> Weight bearing								
Locomotion	<input type="checkbox"/> Wheelchair/Cane/Walker								
	<input type="checkbox"/> Other person wheels								
	<input type="checkbox"/> Put on prosthesis or brace								
	<input type="checkbox"/> Wandering								
Bathing	<input type="checkbox"/> Does not bathe appropriately								
	<input type="checkbox"/> In/out of tub/shower								
	<input type="checkbox"/> Lower body/Upper body								
	<input type="checkbox"/> Cueing								
Dressing	<input type="checkbox"/> Buttons/zippers/snaps/tying								
	<input type="checkbox"/> Inappropriate dressing/layers								
	<input type="checkbox"/> Step by step guidance								
	<input type="checkbox"/> Refuses to change/reapplies dirty								
	<input type="checkbox"/> Put on socks/shoes								
Toileting	<input type="checkbox"/> Getting off toilet								
	<input type="checkbox"/> Poor hygiene								
	<input type="checkbox"/> Empty urinal/BSC								
	<input type="checkbox"/> Clothing up/down								
Eating	<input type="checkbox"/> Setup								
	<input type="checkbox"/> Cut into bite-size pieces								
	<input type="checkbox"/> Encouragement to finish meals								
	<input type="checkbox"/> Step by step instruction								
Bladder & Bowel	<input type="checkbox"/> Scheduled toileting plan								
	<input type="checkbox"/> Pads/briefs used								
	<input type="checkbox"/> Bowel program								
Cognitive	<input type="checkbox"/> Memory problem(s)								
	<input type="checkbox"/> Decision making capacity								
	<input type="checkbox"/> Mood problem(s)								
	<input type="checkbox"/> Behavior problem(s)								
Diet	Good (75%) →								
	Fair (50%) →								
	Poor (25%) →								
	Refused →								
	Supplements →								
Weight & Vital Signs	Weight →								
	Blood Pressure →								
	Temperature →								
	Pulse →								
	Respiration →								
	Sugar Monitoring →								
Level of Care Key: L = Limited E = Extensive T=Total									

Resident's Name

Room Number

Medicaid Number

Signatures and Initials of all Resident Assistants providing assistance this week

Initial	Signature
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify the information on this form is correct and documented services were provided.

Administrator's Signature

Date

I certify the information on this form is correct and documented services were provided.

Nurse's Signature

Date

Comments:

SOUTH CAROLINA OPTIONAL STATE SUPPLEMENTATION (OSS)

CONSENT FORM

Resident Name: _____

Social Security Number: _____

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

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 OSS program any medical information regarding my diagnosis, functional abilities and recommended treatment.

I hereby authorize the South Carolina OSS 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 OSS program.

Date Signature of Client or Responsible Party

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

Date Signature of Witness(es)

COMMUNITY RESIDENTIAL CARE FACILITY ACCESSIBILITY CHECKLIST

Facility Name	RC Number
Physical Address	
Inspectors Name	License Number
<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	Date

If NO is checked for an item please use the comment section or attach a plan to describe the measures the facility will take to assure:

1. Making modifications in policies, practices, and procedures to allow equal access to individuals with disabilities
2. Furnishing auxiliary aids when necessary to ensure effective communication
3. Removing architectural and structural barriers in existing facilities where readily achievable.
4. Providing readily achievable alternative measures when removal of barriers is not readily achievable.

1 - APPROACH AND ENTRANCE		Comments:										
Is there at least one route from site arrival points (parking, passenger loading zones, public sidewalks and public transportation stops) that does not require the use of stairs?	Yes <input type="checkbox"/> No <input type="checkbox"/>											
A - Parking If parking is provided for the public, are an adequate number of accessible spaces provided?	Yes <input type="checkbox"/> No <input type="checkbox"/>											
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="padding: 2px;">Total Spaces</th> <th style="padding: 2px;">Accessible Spaces</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">1 - 25</td> <td style="padding: 2px;">1</td> </tr> <tr> <td style="padding: 2px;">26 - 50</td> <td style="padding: 2px;">2</td> </tr> <tr> <td style="padding: 2px;">51 - 75</td> <td style="padding: 2px;">3</td> </tr> <tr> <td style="padding: 2px;">76 - 100</td> <td style="padding: 2px;">4</td> </tr> </tbody> </table>			Total Spaces	Accessible Spaces	1 - 25	1	26 - 50	2	51 - 75	3	76 - 100	4
Total Spaces	Accessible Spaces											
1 - 25	1											
26 - 50	2											
51 - 75	3											
76 - 100	4											
Of the accessible spaces, is at least one a van accessible space? Note: For every 6 or fraction of 6 parking spaces required by the table above, at least 1 should be a van accessible space. If constructed before 3/15/2012, parking is compliant if at least 1 in every 8 accessible spaces is van accessible.	<input type="checkbox"/> <input type="checkbox"/>											
Are accessible spaces at least 8 feet wide with an access aisle at least 5 feet wide?	<input type="checkbox"/> <input type="checkbox"/>											
Is the van accessible space at least 11 feet wide with an access aisle of at least 5 feet wide or at least 8 feet wide with an access aisle at least 8 feet wide?	<input type="checkbox"/> <input type="checkbox"/>											
Are the access aisles marked so as to discourage parking in them?	<input type="checkbox"/> <input type="checkbox"/>											
Do the access aisles adjoin an accessible route?	<input type="checkbox"/> <input type="checkbox"/>											
Are accessible routes identified with a sign that includes the International Symbol for Accessibility	<input type="checkbox"/> <input type="checkbox"/>											

B - Exterior Accessible Route

Is the route of travel stable, firm and slip resistant?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Is the route at least 36 inches wide.

<input type="checkbox"/>	<input type="checkbox"/>
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Can all objects protruding into the circulation paths be detected by a person with a visual disability using a cane?

<input type="checkbox"/>	<input type="checkbox"/>
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C - Curb Ramps

If the accessible route crosses a curb, is there a curb ramp?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Is the curb ramp, excluding flare, no steeper than 1:48, and at least 36 inches wide?

<input type="checkbox"/>	<input type="checkbox"/>
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At the curb ramp is there a level landing

<input type="checkbox"/>	<input type="checkbox"/>
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D - Ramps

Is there a ramp (other than curb ramps), is it at least 36 inches wide?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Is the surface stable, firm and slip resistant?

<input type="checkbox"/>	<input type="checkbox"/>
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For each section of the ramp, is the running slope no greater than 1:12, i.e. for every inch of height change there are at least 12 inches of ramp run?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Is there a level landing at the top and bottom of the ramp, and that is at least 60 inches long and at least as wide as the ramp?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

If the ramp has a rise higher than 6 inches, are there handrails on both sides?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Is the top of the handrail gripping surface no less than 34 inches and no greater than 38 inches above the surface?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

E - Entrance

Is the main entrance accessible?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If the main entrance is not accessible is there an alternative accessible entrance?

<input type="checkbox"/>	<input type="checkbox"/>
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Do all accessible entrances have signs indicating the location of the nearest accessible entrance?

<input type="checkbox"/>	<input type="checkbox"/>
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If not all entrances are accessible, is there a sign at the accessible entrance with the International Symbol of Accessibility?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Is the clear opening width of the accessible entrance door at least 32 inches, between the face of the door and the stop when the door is open 90 degrees?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Comments:



	Yes	No	Comments:
Is there a front approach to the pull side of the door, is there at least 18 inches of maneuvering clearance beyond the latch side plus 60 inches of clear depth?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the operable parts of the door hardware no less than 34 inches and no greater than 48 inches above the floor or ground surface?	<input type="checkbox"/>	<input type="checkbox"/>	
If there are two doors in a series, is the distance between the doors at least 48 inches plus the width of the doors when swinging into the space?	<input type="checkbox"/>	<input type="checkbox"/>	
Are edges of carpets or mats securely attached to minimize tripping hazards?	<input type="checkbox"/>	<input type="checkbox"/>	
2. ACCESS TO GOODS AND SERVICES			
Does the accessible entrance provide direct access to the main floor, lobby and elevator (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	
A - Interior Accessible Route	Yes	No	
Are all public spaces on at least one accessible route?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the route stable, firm and slip resistant?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the route at least 36 inches wide?	<input type="checkbox"/>	<input type="checkbox"/>	
Do all objects on circulation paths through public areas protrude no more than 4 inches into the path? (e.g. fire extinguishers, signs, drinking fountains, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Are there elevators or platform lifts to all public stories?	<input type="checkbox"/>	<input type="checkbox"/>	
If an elevator is present, are the key pads at a height a person can reach when sitting? (no higher than 42 inches)	<input type="checkbox"/>	<input type="checkbox"/>	
B - Interior Doors	Yes	No	
Is the door opening width at least 32 inches clear, between the face of the door and the stop, when the door is open 90 degrees?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the door threshold edge no more than 1/4 inch high?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the door equipped with hardware that is operable with one hand and does not require tight grasping, pinching and twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Are the operable parts of the hardware no less than 34 inches and no greater than 48 inches above the floor?	<input type="checkbox"/>	<input type="checkbox"/>	
Can the doors be opened easily (5 pounds maximum force)?	<input type="checkbox"/>	<input type="checkbox"/>	

C - Signs

If there are signs designating permanent rooms and spaces do the text characters contrast with their background, are the text letters raised, in Braille and mounted on the latch side of the door?

Yes No

If there are signs providing direction to or information about the interior space do the text characters contrast with their background, are the text letters raised, in Braille and mounted on the latch side of the door?

Yes No

D - Rooms and Spaces

Are hall pathways at least 36 inches wide?

Yes No

Are floor surfaces stable, firm and slip resistant?

If there is carpet is it no higher than 1/2 inch thick and is it attached securely along the edges?

E - Light Switches

Is there clear floor space at least 30 inches wide by at least 48 inches long for a forward or parallel approach?

Yes No

Are the switches no higher than 48 inches above the floor?

Can the switch be controlled with one hand and without tight pinching, grasping, or twisting of the wrist?

F - Seating

Are an adequate number of wheelchair spaces provided?

Yes No

# of Seats	Wheelchair Spaces
4 - 25	1
26 - 50	2
51 - 150	4

see standards 221.2.1

Are wheelchair spaces dispersed to allow location choices and viewing angles equivalent to other seating.

Is there a route at least 36 inches wide to accessible dining seating?

At the dining space is the top of the accessible surface no less than 28 inches and no greater than 34 inches above the floor?

Are the tops of counters or tables between 28 and 34 inches wide?

Are aisles between tables at least 36 inches wide?

Comments:

3 ACCESSIBLE TOILETS AND BATHROOMS

Comments:

	Yes	No
Is there at least one wheelchair accessible bathroom (stall, if applicable) in the facility?	<input type="checkbox"/>	<input type="checkbox"/>
Are there signs at accessible toilets that include the International Symbol of Accessibility?	<input type="checkbox"/>	<input type="checkbox"/>
Is the door opening width at least 32 inches clear, between the face of the door, and the stop, when the door is open 90 degrees?	<input type="checkbox"/>	<input type="checkbox"/>
Does the entry configuration provide adequate maneuvering space for a person using a wheelchair (18 inches beyond the latch side plus 60 inches clear depth)?	<input type="checkbox"/>	<input type="checkbox"/>
Is the threshold edge no more than 1/4 inch high?	<input type="checkbox"/>	<input type="checkbox"/>
Is there door equipment that is operable with one hand and does not require tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>
Are the operable parts of the door hardware mounted no less than 34 inches and no greater than 48 inches above the floor.?	<input type="checkbox"/>	<input type="checkbox"/>
Can the door be opened easily (5 pounds maximum force)?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a clear path to each type of fixture, e.g. lavatory, hand dryer, etc. that is at least 36 inches wide?	<input type="checkbox"/>	<input type="checkbox"/>
Is there floor space available for a person to turn around (a circle at least 60 inches in diameter or a t-shaped space within a 60 inch square)?	<input type="checkbox"/>	<input type="checkbox"/>
Does at least one lavatory have a clear floor space for a forward approach at least 30 inches wide and 48 inches long?	<input type="checkbox"/>	<input type="checkbox"/>
Do no less than 17 inches and no greater than 25 inches of the clear floor space extend under the lavatory so a person using a wheelchair can get close enough to the faucet?	<input type="checkbox"/>	<input type="checkbox"/>
Is the front of the lavatory or counter surface, whichever is higher, no more than 34 inches above the floor?	<input type="checkbox"/>	<input type="checkbox"/>
Are the pipes below the lavatory insulated or otherwise configured to protect against contact?	<input type="checkbox"/>	<input type="checkbox"/>
Can the faucet be operated without tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Comments:
Are soap and other dispensers and hand dryer (if applicable) within reach ranges and usable without tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a grab bar at the toilet at least 42 inches long on the side wall, and located no more than 12 inches from the rear wall?	<input type="checkbox"/>	<input type="checkbox"/>	
If the flush control is hand operated, can it be operated with one hand and without tight grasping, pinching, or twisting of the wrist?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a roll-in shower, or transfer shower? If not is there a transfer bench in the shower?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a hand-held shower?	<input type="checkbox"/>	<input type="checkbox"/>	
4 ADDITIONAL ACCESSIBILITY			
	Yes	No	
If there is a public phone is it accessible to those in a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
Does the phone have a volume control, have large numbers, braille numbers, and large control buttons (volume, redial, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
If the facility has hearing impaired residents, does one telephone have TTY?	<input type="checkbox"/>	<input type="checkbox"/>	
Do fire alarm systems, have both flashing lights and audible signals?	<input type="checkbox"/>	<input type="checkbox"/>	

Disclaimer:

The South Carolina Department of Health and Human Services (SCDHHS) is not responsible for enforcement of the Americans with Disabilities Act (ADA). The information, presented here is intended solely as informational guidance and contract compliance in regards to the Optional Supplementation for Assisted Living Program (OSCAP), and is neither a determination of your legal rights or responsibilities under the ADA, nor binding on any agency with enforcement responsibility under ADA.