South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
December 13, 2012
MB# 12-060

MEDICAID BULLETIN

Phys
Hosp
Med Clin
NF
HH

TO: Providers Indicated

SUBJECT: Referrals to Community Long Term Care (CLTC)

Effective January 7, 2013, the Division of Community Long Term Care (CLTC) will centralize intake activities for all programs operated by CLTC. This includes referrals for nursing home placement, nursing home conversion, Pre-Admission Screening Resident Review (PASRR), home and community based waiver services, children's personal care and nursing services, and Katie Beckett Medicaid Program (TEFRA). When intake activities are centralized, referrals will no longer be accepted at the CLTC Regional Offices. Referrals will only be accepted by one of the methods below.

Telephone
855-278-1637
Fax
803-255-8209
Mail
South Carolina DHHS
Community Long Term Care Intake – J7
P. O. Box 8206
Columbia, SC 29202-8206

The toll free number will not be available until January 7, 2013. To make a written referral, the attached application will need to be completed and submitted. No other written documentation will be needed except the completed PASRR for PASRR referrals. If you would like an electronic copy of the application form or have questions concerning this change, please contact Rhonda Feaster at feaster@scdhhs.gov or 803-898-2532.

Thank you for your continued participation in the South Carolina Medicaid program.

/s/
Anthony E. Keck
Director

Attachment

Community Long Term Care Application For Services

REASON FOR REFERRAL

(Circle appropriate program)

1. Pre-Admission Review
2. Nursing Home Conversion Date:_____
3. Non Medicaid PASRR
4. Community Choices Waiver
5. HIV/AIDS Waiver
6. Ventilator Waiver
7. Children's Personal Care
8. Children's Private Duty Nursing
9. Medically Complex Children
10. TEFRA
11. Money Follows The Person
12. PACE

APPLICANT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Suffix_____

Permanent Address _____

City_____ State _____ Zip Code _____

County_____ Phone Number _____

Social Security Number _____ Medicare Number _____

Medicaid Number _____ Date of Birth _____

DEMOGRAPHIC DATA

(Circle Appropriate Categories)

GENDER
Female
Male

MARITAL STATUS
1. Married
2. Widowed
3. Divorced/Separated
4. Single

RACE
1. White
2. Black
3. Asian
4. Hispanic
5. Indian
6. Other

EDUCATION LEVEL
1. Less than third grade
2. Third through eighth grade
3. Some High School
4. High School Graduate
5. Some College
6. College Graduate

PRIMARY LANGUAGE
Is primary language English?
Yes or No
If no, specify language
_____

PRESENT LOCATION

Name of Facility _____ Address _____

City_____ State _____ Zip Code _____

CONTACT PERSON

Name _____ Address _____

City_____ State _____ Zip Code _____

Home Phone Number _____ Alternate Phone Number _____

Is primary language English? Yes or No If no, specify language: _____

Relationship to applicant

1. Spouse
2. Child/Child's Spouse
3. Sibling
4. Parent
5. Aunt/Uncle
6. Cousin
7. Grandparent
8. Grandchild
9. Niece/Nephew
10. Friend
11. Neighbor
12. Self
13. Other

Reason for referral (circle functional dependencies)

Locomotion Transfer Bathing Dressing Toileting Eating Incontinence Confusion Cognitive Impairment

HIV Referral Only Diagnoses with HIV or AIDS? Yes or No ***Ventilator Waiver Only*** Uses ventilator at least 6 hours daily? Yes or No

Children's Personal Care or Private Duty Nursing Current Medicaid Recipient? Yes or No Needs personal care or nursing service ? Yes or No

Does applicant know a referral is being made? Yes or No

If not, why not? _____

REFERRAL SOURCE

1. DSS
2. DHEC
3. DMH
4. DDSN
5. Council on Aging
6. Hospital
7. Nursing Home
8. Physician
9. CLTC
10. HIV Organization
11. Family/Friend
12. Home Health
13. Community RCF
14. HMO
15. Self
16. DHHS/Eligibility
17. ADRC
18. Hospice
19. Waiver Provider
20. Dialysis Center

Name of Referral Source _____ Agency/Institution _____

Phone Number _____ Address _____

City_____ State _____ Zip Code _____

Signature _____ Date_____

(For CLTC Use Only)

Application Date _____ Program Assistant_____