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
	Authorization Agreement for Electronic Funds Transfer	03/2011
	Duplicate Remittance Advice Request Form	10/2012
	Sample Edit Correction Form	
	Sample Remittance Advice (two pages)	
181	Notice of Admission, Authorization, and Change of Status for Long Term Care (two pages)	02/2012
235	Request for Approval of Non-Covered Medical Expenses	07/2008
236	Log of Incurred Medical Expenses (two pages)	07/2008
185S	Complex Care Supplemental Assessment Form (two pages)	12/2012
247	Social History for MI Level II PASARR Screening (two pages)	07/1992
248	Social History for MR Level II PASARR Screening (two pages)	07/1992
249	PASARR Referral Packet Cover Letter	05/2007
250	Psychiatric Evaluation Level II (three pages)	01/1992
185	Level of Care Certification Letter (two pages)	11/2003
121	Consent Form	06/2003
234	PASARR Level I Screening Form (two pages)	01/1996
210	Resident Case Mix Classification Change (two pages)	08/2011
1231 ME	Request for Assessment of Level of Care	06/2003
	PFAs Core Curriculum — Attachment B (two 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

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**

SCDHHS (Revised 10/2012)

Sample Edit Correction Form

RUN DATE 02/01/2005 000091455 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0503100163132500G
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 42526 ECF 42526 PAGE 1 OF 1
ANALYST ID LONG TERM CARE EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N ORIGINAL CCN:
ADJ CCN:
EDITS

PROVIDER ID	RECIPIENT ID	RECIPIENT NAME	P	AUTH NO
000000000	0000011000	John J Doe		
		DATE OF BIRTH 07/02/1912 SEX M		

INSURANCE EDITS

CLAIM EDITS
673
156

LEVEL CARE	BEGIN DATE	TOTAL DAYS	NH DAILY RATE	MONTHLY INCOME	AMT REC'D INS	NET CHARGE	PAT DAILY RATE	INCURRED MONTHLY EXP
6	11/24/04	05				472.35	94.47	

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
****

****

RESOLUTION DECISION _R_

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 100122
COLUMBIA, S.C. 29202-0122

PROVIDER:
ACME NURSING FACILITIES

P O BOX 000000
ANYWHERE SC 00000-0000

INSURANCE POLICY INFORMATION
000 Any Insurance Company

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle, and a rejected claim.

PROVIDER ID. 0123NF

000000000 DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE
NURSING CARE SERVICES

PAYMENT DATE 05/04/2007

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	CODE L DYS	AMNT. OF BILL	TITLE 19 PAYMENT MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F M I I	PATIENT MED EXP &INCOME	BG END SERVCE DATES	INSTN DAILY RATE	PATNT DAILY RATE
	0425700632135900G		0		4029.29	P	0000011000	DOE	J J				
	01	120106-1201	2 31		4029.29	P				155.91	1 1	135.02	129.88
	VOID OF ORIGINAL CCN 0507300410360000G PAID 20050318												
	0507300410136000G		0		-805.00	P	0000011000	DOE	J J				
	01	020107-0201	1 28		-805.00	P				2975.56	1 1	135.02	28.75
	REPLACEMENT OF ORIGINAL CCN 0507300410136000G PAID 20050318												
	0509700048600100G		28		750.96	P	0000011000	DOE	J J				
	01	020107-0228	1 28		750.96	P				3029.64	1 28	135.02	26.82
	0503100163132500G		0		0.00	R	0000011000	DOE	J J				
	01	112406-1128	6 5		0.00	R					24 28		94.47
								EDITS: L00 673		L00 156			
TOTALS		CLAIMS 3	0	0.00	3975.25								

$0.00 | $3975.25

SCHAP PG TOT | MEDICAID PG TOT
$3975.25

SCHAP TOTAL | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

PROVIDER NAME AND ADDRESS

ACME NURSING FACILITIES
P O BOX 000000
ANYWHERE SC 00000-0000

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a final page with a claim-level Adjustment without a corresponding Replacement claim.

PROVIDER ID. 0123NF

000000000
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 05/04/2007

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	O D	ORG CHECK DATE	ORIGINAL CCN
	0509420344031700U					-1044.12	P	0000011000	DOE	J	J		050318	05730037623600G
	TOTALS		00001			-1044.12								

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
	$3975.25	0.00	0.00	0.00

ADJUSTMENTS		
-979.88	0.00	

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
	2995.37	12424579

PROVIDER NAME AND ADDRESS

ACME NURSING FACILITIES
P O BOX 000000
ANYWHERE SC 00000-0000

South Carolina Department of Health and Human Services
Notice of Admission, Authorization & Change of Status for Long Term Care
MUST BE TYPED OR COMPLETED IN BLACK OR BLUE INK

SECTION I. IDENTIFICATION OF PROVIDER AND PATIENT (COMPLETED BY SCDHHS OR LONG TERM CARE FACILITY STAFF)

1. BENEFICIARY NAME	2.BIRTH DATE (MO-DY-YY)	3. MEDICAID NO. (10 DIGITS)
4. FACILITY NAME	5.COUNTY OF RESIDENCE	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX
7. FACILITY ADDRESS	8. PROVIDER MEDICAID ID#	9. LAST DATE MEDICARE EXHAUST / 10. DATE OF REQUEST

SECTION II – TYPE OF COVERAGE AND STATISTICAL DATA

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☐ SKILLED CARE (LOC1) ☐ INTERMEDIATE CARE (LOC2) ☐ SNF COINSURANCE (MEDICARE) ☐ BEDHOLD (LOC5)

(B) CHANGE IN TYPE OF CARE: FROM _____ TO _____ DATE: _____ (MO-DY-YY)

(C) MEDICAID ADMITTANCE DATE: _____ (MO-DY-YY)

(D) TRANSFERRED TO ANOTHER FACILITY: _____ (MO-DY-YY) _____ (NAME OF OTHER FACILITY)

(E) TRANSFERRED FROM ANOTHER FACILITY: _____ (MO-DY-YY) _____ (NAME OF OTHER FACILITY)

(F) TRANSFERRED TO HOSPITAL: _____ (MO-DY-YY) _____ (NAME OF HOSPITAL)

(G) READMITTED FROM HOSPITAL STAY: _____ (MO-DY-YY)

(H) NUMBER OF DAYS ABSENT FROM FACILITY: _____ COVERED DAYS: _____ NON-COVERED DAYS: _____

(I) TERMINATION DATE: _____ (MO-DY-YY) DATE OF DEATH: _____ (MO-DY-YY) ☐ RETURNED HOME (NOTIFY ELIGIBILITY)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: _____ (MO-DY-YY)

(K) COINSURANCE DATES THIS BILL: FROM: _____ (MO-DY-YY) THROUGH: _____ (MO-DY-YY) NO. OF DAYS: _____

(L) NON-COVERED MEDICAL EXPENSE: AMOUNT: _____ ☐ FORM 236 ATTACHED

(M) ACTION: _____ DATES OF SERVICE: _____ TI W- _____
ACTION: _____ DATES OF SERVICE: _____ TI W- _____

COMMENTS:

SECTION III – AUTHORIZATION AND CHANGE OF STATUS (TO BE COMPLETED BY SCDHHS MEDICAID ELIGIBIILTY WORKERS ONLY)

12. RECOMMENDATION OF SCDHHS MEDICAID ELIGIBLITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A) AUTHORIZATION TO BEGIN DATE: _____ (MO-DY-YR)

(B) APPLICANT NOT QUALIFIED FOR LONG TERM CARE BECAUSE: ☐ DOES NOT MEET FINANCIAL CRITERIA ☐ DOES NOT MEET NON-FINANCIAL CRITERIA

(C) BENEFICIARY'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) $_____

(D) CHANGE IN BENEFICIARY INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: _____ (MO-YR) $_____

(E) NAME CHANGE: FROM: _____ TO _____

(F) OTHER:

SIGNATURE

_____ _____
SCDHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY ☐ **SIGNATURE NOT REQUIRED** DATE

SUMMARY OF INSTRUCTIONS REGARDING USE OF THE DHHS FORM 181 (February 2012)

I. GENERAL INFORMATION:

The DHHS FORM 181 is utilized by Nursing Facilities (NF's), Intermediate Care Facilities For the Mental Retardation (ICF/MR's), Swing-Bed Hospitals (SB's), and/or SCDHHS Medicaid Eligibility Workers. The DHHS FORM 181 is authorization by the Department of Health and Human Services for payment and reimbursement for NF, ICF/MR, and SB services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider Services. **A DHHS FORM 945 should accompany all retroactive determinations over one year old for eligibility or recurring income.**

II. DETAILED INSTRUCTIONS: How prepared – Typewritten

A. Section I – Identification of Provider and Patient:

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 6. This suffix (either alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card). The Provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider #.**

B. Section II – Type of Coverage and Statistical Data:

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in level of care changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates. Line Item M is the area in which the provider specifies the dates of service to be processed and selects the action to be taken on the specified dates of service. Level of care should be reported on all DHHS Form 181s.

C. Section III – Authorization and Change of Status:

Only the SCDHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SCDHHS Medicaid Eligibility Approval Authority/Supervisor or authorized representative must sign and date each form for all new admissions, income changes, and discharges home that affect income liability.

III. COINSURANCE:

In the case of filing for Medicare Coinsurance, a SNF Authorizing DHHS FORM 181 must be completed for each Medicare spell of illness. Coinsurance periods are billed using a copy of the initial signed authorization. Coinsurance dates must be supported by EOMBs; must not cross a calendar month; and the service dates must be consecutive. The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly billing. **NOTE:** Effective with dates of service 12/01/01, DHHS no longer reimburses nursing facilities, ICFs/MR for Part A SNF coinsurance. Swing Bed Hospitals are paid coinsurance. **Coinsurance claims should never be sent with the monthly billing.**

IV. DISTRIBUTION PREPARATION AND ROUTNG OF FORM:

The Provider of services will normally initiate these forms. The SCDHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The Provider of services must forward the forms to the appropriate SCDHHS Medicaid Eligibility Worker only when signature authorization in Section III is required.

V. DISTRIBUTION OF FORM:

A. Original Submitted by Provider for claims processing at MCCS.
Copy Retained and kept on file by the appropriate SCDHHS Medicaid Eligibility Worker.
Copy 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. Staple all 181 forms together for each patient.

Mailing address for end of month claims:
MEDICAID CLAIMS RECEIPT - NF CLAIMS SECTION
POST OFFICE BOX 100122
COLUMBIA, SOUTH CAROLINA 29202-3122

Overnight delivery address for end of month claims:
MCCS-NF-AW-220
CLAIMS RECEIPT - NF CLAIMS SECTION
8901 FARROW ROAD
COLUMBIA, SC 29203 -8930

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Approval of Non-Covered Medical Expenses

FROM: _____
_____
_____
_____
(Name & Address of Facility)

TO: South Carolina Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, South Carolina 29202-8206

Regarding: _____ _____
(Beneficiary's Name) (Medicaid ID#)

Part I
(To be completed by facility)

Description of item/service received:
_____
_____
_____

Reason item/service is a questionable deduction or needs prior approval:
_____
_____
_____

Cost of item/service:
_____

Part II
(To be completed by SCDHHS)

Item/Service approved for deduction:
☐ Yes ☐ No (check one)

If Yes, $ _____ may be deducted.

Signature: _____ Date: _____
Division of Medicaid Policy and Planning

SCDHHS Form 235 (Rev. 07/08)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Log of Incurred Medical Expenses

For the Month of _____

A brief description of expenses which can be deducted, including the limits, is found on the back of this form.

Beneficiary's Name: _____

Medicaid ID Number: _____

Month: _____

Item/Service	Date Rendered	Date Bill Provided to Facility	Amount Billed for Item/Service	Lesser of Cost or Allowable Deduction
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
		Total	_____	

Monthly Recurring Income (SCDHHS Form 181) _____

Incurred Monthly Expenses
(Not to Exceed Monthly Recurring Income) _____

Amount carried over to next month** _____

*If actual cost is less than the limit found on the back of this form, enter actual cost. If actual cost is greater than the limit, enter the limit amount.

**If incurred monthly expenses exceed monthly recurring income, the difference can be carried forward to the next month. Put the difference on the first line of next month's log sheet. Include the statement "Prior Month Carry Forward" in the item/service line and the amount to be carried forward in the "Lesser of Cost or Allowable Deduction" column.

The following deduction amounts outlined replace amounts determined in 1989:

1. Eyeglasses
   - Not otherwise covered by the Medicaid program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee; and
   - A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.

2. Dentures
   - A one-time expense;
   - Not to exceed $651.00 per plate or $1320.00 for one full pair of dentures; and
   - A licensed dental practitioner must certify necessity.
   - An expense for more than one (1) pair of dentures must be prior approved by State Office.

3. Denture Repair
   - Not to exceed $77.00 per occurrence; and
   - A licensed dental practitioner must certify the necessity for denture repair.

4. Physician and other medical practitioner visits that exceed the yearly limit
   - Not to exceed $69.00 per visit.

5. Hearing Aids
   - A one-time expense;
   - Not to exceed $1000.00 for one or $2000.00 for both; and
   - A licensed practitioner must certify the necessity for hearing aids.
   - An expense for more than one hearing aid must be prior approved by State Office.

6. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

7. Other non-covered medical expenses which are recognized by State Law but not covered by Medicaid, or any other third party, not to exceed $20.00 per item/service. These non-covered medical expenses must be prescribed by a licensed practitioner.

Items/services presented by the beneficiary for deductions which require prior approval or are questionable should be submitted to the Division of Medicaid Policy and Planning. The request for prior approval should be made on the SCDHHS Form 235 and should be mailed to:

South Carolina Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, South Carolina 29202-8206

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

COMPLEX CARE PROGRAM SUPPLEMENTAL ASSESSMENT FORM

Applicant_____ Medicaid #_____

Name & Title of Person Completing Form _____

Agency_____ Date Completed_____

Phone Number _____ E-mail Address_____

Category/Treatment	Supplies/Equipment	Additional Information/Staff Required
Wound/decubitus care	❑ Compression Wrap ❑ Collagen Dressing ❑ Cell Mist Therapy ❑ Antimicrobial Dressing ❑ Negative Pressure Therapy, i.e. wound vac ❑ Wound care consultation and treatment	
Tracheostomy	❑ Tube/cannula ❑ Aseptic dressing ❑ Tracheal cleaning/aspiration	Frequency_____
Oral Suctioning	❑ Tracheal aspiration Purpose _____ _____	Frequency_____
Parenteral Fluids	❑ 2 weeks or more ❑ IV Type of Fluid _____ Site _____	Expected duration _____
Disruptive Behavior List conditions – _____ _____	Describe Behaviors (Attach additional pertinent information)	60% of time ❑ PASRR Level II completed (Recommendation attached) ❑
Diagnosis of Morbid Obesity	❑ Bed ❑ Lift Type_____ ❑ Wheel chair	Height_____ Weight_____
Goal directed therapies – Medicaid only individuals	❑ PT ❑ OT ❑ ST Frequency_____ Duration_____	
Ventilator Dependent (life sustaining for 6 or more hours a day)	Describe & List	
Dialysis		❑ Peritoneal ❑ Hemodialysis
HIV		
Totally dependent in all activities of daily living	Describe care needs	

ADL SELF-PERFORMANCE-- (Code for client's PERFORMANCE during last 7 days--Not including setup)

0. INDEPENDENT - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days.
2. LIMITED ASSISTANCE - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days
3. EXTENSIVE ASSISTANCE - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time:
--Weight-bearing support
--Full caregiver performance during part (but not all) of last 7 days
4. TOTAL DEPENDENCE - Full caregiver performance of activity during entire 7 days

DEFINITIONS

A. TRANSFER - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/ from bath/toilet)
B. LOCOMOTION - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair.
C. DRESSING - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.
D. EATING - How the client eats and drinks (regardless of skill).
E. TOILET USE - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

LOCOMOTION	
EATING	

BATHING--How client takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)

0. Independent--No help provided
1. Supervision--Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

BATHING	

CONTINENCE SELF-CONTROL CATEGORIES (Code for client performance over 14 days)

0. CONTINENT - Complete control
1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT - BLADDER, tends to be incontinent daily, but some control present; BOWEL, 2-3 times a week
4. INCONTINENT - Has inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel

BOWEL CONTINENCE	***Control of bowel movement, with appliance or bowel continence programs, if employed.***	
BLADDER CONTINENCE ***underpants),***	***Control of urinary bladder function (if dribbles, volume insufficient to soak through*** With appliances (e.g., Foley) or continence programs, if employed.	

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

❑ Approved Effective Date From_____ To_____

❑ Denied Reason(s) _____

_____

_____

_____

SCDHHS Representative _____ Date:_____

Once request is approved/denied, SCDHHS will forward a completed copy of this form to the nursing facility within five (5) days.

SOCIAL HISTORY FOR MI LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____
2. Ability to Communicate: _____
3. Mental Status: _____
4. Observed Behavior: _____

_____

5. Current Living Situation: _____

_____

6. Significant Family History: _____

_____

7. Social/Personal and Support Systems: _____

_____

_____

8. Maladaptive/Inappropriate Behavior: _____

_____

_____

9. Past Mental Health History: _____

_____

_____

10. Medical History & Impact of Medical Problems on Individual's Functioning: _____

_____

_____

11. Present Treatment: _____

_____

12. Summary/Comments: _____

_____

_____

Signature: _____ Date:

User's Guide for Social History for MI Level II PASARR Screening

The intent of the Social History is to obtain further information which relates to the MI indicators and is not normally included on the 1718 and Level I screening.

2) Comment on all forms of communication, i.e. verbal, sign language, etc.

3) Comment on Mental Status - Such as alert, oriented, attention span, memory, awareness, thought process, etc.

4) Comment on Observed Behavior: Such as facial expression, eye contact, repetitive behavior, etc.

5) Comment on family composition, home environment, etc.

7) Comment on the ability to form and maintain relationships, interact with the community, positive-negative interactions, etc.

8) Comment further on behavioral indicators.

9) Include hospitalization treatment, out-patient treatment, compliance to treatment, etc.

11) Comment on present mental health treatment.

12) Include informants, reliability of information, and a brief evaluation of client.

SOCIAL HISTORY FOR MR LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____
2. Ability to Communicate: _____
3. Mental Status: _____
4. Observed Behavior: _____

_____

5. Birth and Early Development History: _____

_____

_____

6. Social Development: _____

_____

7. Social/Personal Significant Family History: _____

_____

8. Independent Living Development/Ability: _____

_____

9. Maladaptive/Inappropriate Behavior: _____

_____

10. Medical History: _____

_____

11. Impact of Medical Problems on Individual's Functioning: _____

_____

_____

12. Community Social Supports: _____

_____

_____

13. Summary/Comments: _____

_____

_____

Signature: _____ Date:

DHHS Form 248 (7/92)

User's Guide for Social History for MR Level II PASARR Screening

The intent of the Social History is to obtain further information which relates to the MR indicators and is not normally included on the 1718 and Level I screening.

2. Comment on all forms of communication, i.e. verbal, sign language, etc.

3. Comment on mental status such as alert, oriented, attention span, memory, awareness, thought process, etc.

4. Comment on observed behavior such as facial expression, eye contact, repetitive behavior, etc.

5. Comment on developmental milestones, speech and language development, cognitive development, significant education, and/or vocational history, etc.

6. Comment on relationships with others, interpersonal skills, social functioning, recreational and/or leisure activities.

8. Comment on independent living skills such as financial management, survival skills, ability to make decisions, etc.

9. Comment further on behavioral indicators.

10. Comment on such conditions as seizures, other neurological abnormalities, etc.

12. Comment on past or present association with DDSN and/or community/social supports.

13. Include informants, reliability of information, a brief evaluation of client and legal status, if pertinent.

PASARR REFERRAL PACKET COVER LETTER

Date:

To: _____ From:

_____

_____

RE:

Dear: _____:

The above named client has been reviewed through Community Long Term Care for possible nursing home placement.

Information received from the Level I screening indicates that this client may have _____. Therefore, as required by federal guidelines, we are referring this client to you for further evaluation and determination. Enclosed are the forms checked below.

We appreciate your assistance and look forward to receiving your report as soon as possible. If you have any questions, please feel free to call me at _____.

Sincerely,

Enclosures:
- ____ Level I Screen - Mini Mental State Exam Psychiatric Evaluation
- ____ Client Consent Form
- ____ SC Long Term Care Assessment Form (1718)
- ____ Social History
- ____ Physician's History and Physical
- ____ Copies of Hospital/Nursing Home Records
- ____ Other

May 15, 2007

DHHS Form 249

SOUTH CAROLINA PSYCHIATRIC EVALUATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES LEVEL II

NAME:	SSN:	DATE:

I. PSYCHIATRIC HISTORY

A. Hospitalizations

1. Has the patient had a history of hospitalizations for psychiatric illnesses? Yes ____ No ____ Unknown ____
2. Number of hospitalizations: _____
3. Date and duration of most recent psychiatric hospitalization: Date: ____/____/____ Total number of days hospitalized: _____
4. Major symptoms and/or diagnosis: (Report as described or stated in medical records)

_____

B. Outpatient History

1. Has the patient ever been in outpatient treatment for one year or longer? Yes ____ No ____ Unknown ____
2. Which of the following services did the patient receive?

_____	Counseling	_____	Day Treatment	_____	Short-term Outpatient	_____	Crisis Intervention
_____	Medication	_____	Residential Treatment	_____	Local Inpatient	_____	Case Management

3. Major symptoms and/or diagnosis. Report as described or stated in the medical records.

_____

II. PSYCHIATRIC CONDITION

A. Affect. Affect is the emotion that people express when interacting with others and their environment. A normal affect is when people laugh or show sadness or pleasure or grief in a manner consistent with the topic being discussed or the event being observed. A flat affect is to express little or no affect at all; a labile affect changes frequently and is often inconsistent with the subject being discussed or the event. A euphoric affect is exceptionally high with no obvious basis for it. Affect is changeable, whereas mood is a constant or fundamental emotion underlying all interactions.

Y = Yes N = No U = Unspecified or Unknown

Normal	Y N U	Angry	Y N U	Other (Describe)_____	
Flat or blunt	Y N U	Labile or changeable	Y N U	_____	
Sad or blue	Y N U	Euphoric or elated	Y N U	_____	

B. Mood. Mood is the constant or fundamental emotion. For example, a depressed person may laugh but there is a sad or cynical quality to it. Facial expression and body language may continue to reflect a despondency. An anxious mood might be expressed as nervousness or lack of confidence in responses given. Fearfulness might be expressed as concern that responses will elicit negative consequences. Elation might be expressed as feeling "on top of the world" when circumstances should leave the person feeling otherwise. A normal mood is one that is consistent with the person's circumstances and denotes appropriate acceptance of circumstances with constructive adaptability.

Depressed	Y N U	Anxious	Y N U	Other (Describe)_____	
Elated	Y N U	Normal	Y N U	_____	
Fearful	Y N U			_____	

C. Thinking Patterns. Thinking patterns are reflected in the patient's capacity to respond to questions and engage in conversation. If patterns are incoherent or confused, the response is illogical or unrelated. If patterns are loose or tangential that questions or conversational points result in the patient referencing something that is not connected or pertinent to the content of the conversation, then perseverance or obsessiveness is reflected by constant repetition of a point, observation or constant repetition of a point, observation or concern, and an inability to move to other topics.

Incoherent or confused	Y N U	Other (Describe)_____
Loose or tangential	Y N U	_____
Persevering or obsessive	Y N U	_____

NAME:

D. Sensorium and Thought Disorders. These are disorders common to various psychoses.

1. Auditory Hallucinations: Commonly thought of as "hearing voices". Y N U
2. Visual Hallucinations: Seeing things and/or people that are not there. Y N U
3. Delusions: A false personal belief based on incorrect inference. Y N U
   a. Persecutory: The feeling that people are out to harm one. Y N U
   b. Grandiose: An exaggerated sense of Importance or power. Y N U
4. Hypochondriacal: A preoccupation with the fear or belief of having a disease. Y N U
5. Obsessive or ritualistic: Recurrent, persistent thoughts/actions that are not experienced as voluntary; perceived as compelling. Y N U
6. Phobias: An irrational fear of a specific object, activity or situation. Y N U
7. Acted on content. Has the patient ever acted in response to or as a result of a delusion or hallucination? Y N U
   Describe the action or behavior:
   _____
   _____

E. Suicidal/Homicidal Potential. Direct questioning is often the best approach to evaluating suicidal/homicidal potential.

1. Expresses ideas of suicide or homicide. Example: Have you ever had thoughts of hurting yourself? Have you thought of how you would do it? Y N U
2. Has made plans for suicide/homicide. Example: Have you ever tried to hurt yourself? What did you do? Y N U
3. Has made suicidal/homicidal gestures or attempts. Example: Have you ever felt so angry you wanted to hurt someone, or attempted to? Y N U

F. Object Relationship to Others. This is the patient's capacity to relate to others and problems in relating to others.

1. Cooperative: An ease and confidence; give and take eye contact and animation. Y N U
2. Paranoid: Guarded, suspicious, untrusting attributes; negative intent to questions and actions of others. Y N U
3. Withdrawn: Little/no eye contact, pulling/turning away, asks to be left alone, volunteers little. Y N U
4. **Resistive: Withholding of information, answers brief and literal; gives little. Y N U**
5. Fearful: Anxious about purpose or intent; Physically holding self or pulls away; worries, frets. Y N U
6. Hostile: Belligerent, angry, refuses to answer or deliberately misleads or misinforms; uncooperative. Y N U
7. Other (Describe):_____
   _____

G. Speech.

1. Pressured: Speech that is difficult to interrupt because of its speed, amount, or accelerated pace. Y N U
2. Blocked: Interrupted speech before a thought or idea has been fully expressed. Y N U
3. Rapid: A nearly continuous flow of speech of an extremely accelerated pace. Y N U
4. Echolalic: Patient repeats the words/phrases of others-not to be confused with efforts to clarify questions. Y N U
5. Slow: Long pauses between words; may appear that patient has to give much thought to each word. Y N U
6. Nonsensical: Speech may consist of words or sounds but they have no clear relationship to a thought or idea. Y N U
7. Normal: Speech consists of words that are organized to communicate coherent thoughts and ideas. Y N U

H. Behavior.

1. Agitated or hyperactive: Very mobile, pacing, fidgety, always busy. Y N U
2. Combative: Strikes others without provocation; unpredictable, aggressive, acting out behavior. Y N U
3. Repetitive purposeless activity: Repeats the same behavior over and over with no clear purpose. Y N U
4. Abnormal, involuntary movements: Parts of the body appear to jerk or twitch. Y N U
5. Rigid body and/or extremities: Patient's body appears rigid; patient does not move voluntarily; wooden. Y N U
6. Slow or lack of body movements: Patient moves voluntarily but extremely slow. Y N U
7. Motor restlessness: Restless feeling from within; will rub arms/legs; moves legs up and down; cannot relax. Y N U
8. Gait abnormality: Writhing, dancing or shuffling motion to gait. Y N U
9. Other Describe):_____
   _____

CLIENT NAME:	**SSN:**

III. INDEPENDENT EVALUATION REPORT AND RECOMMENDATION

The above named client has been identified as having medical needs sufficient to require nursing facility care. The individual is also suspected of having a mental illness. A review of the individual's current physical, mental and functional status, psychosocial history, psychiatric history and drug history was conducted. After prioritizing the physical and mental needs of this individual, my findings are as follows:

____ 1. The individual exhibits no evidence of a mental illness which would require any mental health services above those required to be provided by a Medicare/Medicaid certified nursing facility.

____ 2. The individual has a mental illness that is stable or in remission under his/her current treatment regime.

____ 3. The individual has a mental illness for which he/she is in need of psychiatric/mental health treatment services, as indicated in the recommendations indicated below. These needs can be appropriately met in a Department of Mental Health facility or a nursing facility.

____ 4. The individual has a serious acute mental illness and is in need of specialized services by psychiatric professionals.

DIAGNOSIS:_____

_____

_____

Summary of individual's pertinent history and current status, including positive traits or developmental strengths and weaknesses or developmental needs per requirements of §483.128(g):

Specific psychiatric/mental health services recommended to meet the individual's needs:

Basis for these conclusions:

Physician Signature:	Date:

SOUTH CAROLINA COMMUNITY LONG TERM CARE

LEVEL OF CARE CERTIFICATION LETTER

FOR

MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

South Carolina Community Long Term Care has evaluated your application and has determined that:

- ☐ According to Medicaid criteria, you do not meet medical requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long-term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.
- ☐ According to Medicaid criteria, you meet the medical requirements to receive long-term care at the following level:

  ☐ SKILLED ☐ INTERMEDIATE

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long-term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.

Telephone No.

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

- ☐ **If the location of care is a hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG-TERM CARE FACILITY.**

FOR LONG-TERM CARE FACILITY USE

- ☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)
- ☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date:_____

Nurse Consultant Signature:_____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

DHHS FORM 185 (Nov. 2003)

APPEALS

As a Medicaid nursing home or home and community-based waiver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification:

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received, pending the decision, to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time, and place the hearing will take place.

In your request for a fair hearing you must state with specificity what issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of this notification.

SOUTH CAROLINA COMMUNITY LONG TERM CARE

CONSENT FORM

Client Name: _____

Social Security Number: _____

I understand as part of my application for long term care services in the community or a Title XIX nursing home, my condition must be evaluated by the South Carolina Community Long Term Care Program.

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals and organizations 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 Community Long Term Care any medical information regarding my diagnoses and recommended treatment.

I hereby authorize Community Long Term Care to release information on my behalf to physicians, hospitals, health and human service organizations, health and human service agencies, family members and/or other persons directly involved with my care.

I understand 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 I, or my responsible party, may be contacted for additional information.

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 until _____, revoked by me in writing, or until such time as my case is closed by Community Long Term Care.

Date: _____ _____
Signature of Client or Responsible Party

_____
If Signed by Responsible Party, State Relationship and Authority to Sign.

Date: _____ _____
Signature of Witness

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

Name:	Date of Review:
SSN:	Location at assessment:
Medicaid: Non-Medicaid:	CLTC#:
Date of birth:	Referral source:
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?		
2. IQ tested below 70?		
3. Was time of test prior to age 22?		
4. Does client have 3rd grade education? If not, state reason in Comments Section.		
5. Adaptive behavior: Could client ever perform self care activities?		
- Did he/she help care for spouse/parents/children?		
- Was client ever able to cook and perform household duties?		
- Was client gainfully employed? If not, explain in Comments Section.		
- Did client have driver's license?		
6. Cognitive Functioning:		
- Memory: Does client remember what he/she had for breakfast or lunch?		
- Simple math: Can client add 12 + 8?		
- Concept formation: Can client describe the difference between a fish and dog?		

7. Comments: _____

_____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No ___ Yes ___ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. (Give dates of treatment) If no hospitalization, indicate here: _____

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ ___/___/___ to ___/___/

3. Current behavioral indicators:

Attempted suicide	___	Unrealistic fear of strangers	
Assaultive	___	Self-mutilation	
Incessant loud talking	___	Combative	
Uncooperative	___	Social isolation	
Hostile	___	Destruction of property	
		None of these indicators:	

4. Comments: (Include explanation of major symptoms): _____

_____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

NAME: _____ **SSN**: _____

III. LIST ALL PSYCHOTROPHIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

IV. RECOMMENDATION OF REVIEWER:

____ Recommend further evaluation based on mental retardation indicators.
____ Recommend further evaluation based on mental illness indicators.
____ No further evaluation recommended.
____ No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)

V. PERTINENT INFORMATION

____ IMD admission requested; if so, indicate facility: _____
____ Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: _____ CLTC Area # _____

Signature and title of assessor: _____

Agency/Institution completing form: _____

Admitting Nursing Facility: _____ Date of Admission (if known) _____

FOR CLTC/IOC USE ONLY

FOR CLTC USE ONLY
Reviewed by Nurse Consultant _____ (initials)
Date Reviewed: _____

VI. ADVANCE CATEGORICAL DETERMINATION

____ Advance categorical determination that specialized services are not required:

____ 1. Severity of physical impairments overrides need for specialized services (MI only)
____ 2. Nursing facility respite not to exceed 14 days (MR or MI)
____ 3. Emergency admission due to suspected abuse/neglect under authority of DSS (MR or MI)
____ 4. 30-Day time limited certification (MR or MI)
____ 5. Mental retardation with concurrent diagnosis of dementia (MR only)

Signature of CLTC Nurse Consultant:

Date sent to nursing facility: Initials:

South Carolina
Department of Health and Human Services
Resident Case Mix Classification Change

Facility Name _____

Resident Name_____ **Social Security #**_____

Resident Medicaid #_____ **Attending Physician**_____

Your case has been reviewed by the Interdisciplinary Team to determine if it is medically necessary for you to continue to receive nursing facility care.

1. According to current Medicaid criteria, it has been determined that your classification has been changed to:

   - ❑ Skilled Care
   - ❑ Intermediate Care

The above classification change has no impact on your continued stay in the nursing facility.

2. According to current Medicaid criteria, it has been determined that:

   - ❑ You no longer need nursing facility, ICF/MR, or psychiatric IMD care. This does not mean that you do not need personal or other care, and does not mean that you cannot continue to receive skilled, intermediate (Including ICF/MR), or psychiatric IMD care. It does mean that the Medicaid program will not continue to pay for such care. The county Department of Health and Human Services will notify you of the proposed date for termination of your benefits.

If you disagree with this determination, please read the reverse side of this notification.

Signature _____ **Effective Date** _____

Cc: Recipient
Responsible Party
Administrator of Facility
County DHHS Office
*SCDHHS Division of Community and Facility Services

*(Less Than Intermediate Only)

APPEALS

AS A MEDICAID PATIENT, YOU HAVE A RIGHT TO A HEARING REGARDING THIS DECISION.

1) YOU HAVE A RIGHT TO APPEAL WITHIN SIXTY (60) DAYS;
2) IF YOU APPEAL WITHIN TEN (10) DAYS YOUR MEDICAID BENEFITS WILL CONTINUE UNTIL A DECISION IS MADE BY THE HEARING PANEL;
3) IF THE HEARING PANEL DOES NOT DECIDE IN YOUR FAVOR, ACTION WILL BE INITIATED TO RECOUP MEDICAID PAYMENTS MADE IN EXCESS OF 30 DAYS BEYOND THE INITIAL ADVERSE DECISION. YOU MUST REPAY THE MEDICAID PROGRAM FOR PAYMENTS DURING THE TIME YOU WERE INELIGIBLE;
4) IF YOU DO NOT WANT YOUR BENEFITS TO CONTINUE WHILE THE HEARING PANEL IS DECIDING ON YOUR CASE, YOU MUST REQUEST IN WRITING THAT YOUR BENEFITS BE STOPPED.

ALL APPEAL REQUESTS SHOULD BE SUBMITTED TO:

APPEALS AND HEARINGS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
POST OFFICE BOX 8206
COLUMBIA, SC 29202

YOU OR YOUR REPRESENTATIVE WILL BE NOTIFIED OF THE DATE, TIME AND PLACE THE HEARING WILL TAKE PLACE.

South Carolina Department of Health and Human Services

REQUEST FOR ASSESSMENT OF LEVEL OF CARE

From: _____ DHHS

_____

_____

To: _____

_____

_____

The individual named below has applied for Medicaid. Please complete an assessment immediately and forward it to Community Long Term Care (CLTC) or the Department of Disabilities and Special Needs (DDSN) for a determination of level of care.

Applicant		
Name of Applicant:		Date of Birth:
Home Address:		Telephone Number:
Social Security Number:	Date of Medicaid Application:	Category of Application:
Directions to Home:		

Authorized Representative	
Name of Authorized Representative:	Relationship to Applicant:
Home Address:	
Home Telephone Number:	Work Telephone Number:

Medicaid Worker's Signature: _____ Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA PAID FEEDING ASSISTANTS CORE CURRICULUM

A. Basic Infection Control Practices - 1 hour

1. Describe basic infection control principles and proper handwashing techniques during meal service and feeding of a resident.
2. Demonstrate proper handwashing technique.

B. Respecting Resident's Rights - 1 hour

1. Describe the Resident's Bill of Rights.
2. Describe a minimum of two examples of promoting resident's rights during mealtime while feeding or assisting to feed a resident.
3. Define resident's rights to protection and confidentiality.

C. Communication and Interpersonal Skills - 1 hour

1. Describe and demonstrate appropriate social interaction and communication during feeding.
2. Describe several types of communication techniques as well as barriers to communication.
3. Describe the importance of effective communication.
4. Identify and describe appropriate responses to resident behavior, i.e. dementia resident.

D. Safety and Emergency Procedures - 1 hour

1. Describe signs and symptoms of choking.
2. Demonstrate management of obstructed airway (Heimlech Maneuver).
3. Describe the facility's emergency response plan, i.e., call system.

E. Feeding Techniques, Assistance with Feeding and Hydration - 3 hours

1. Demonstrate the knowledge that a feeding assistant feeds only residents who have no complicated feeding problems, including, but not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
2. Describe feeding techniques and hydration measures.
3. Demonstration of selecting proper diet and meal intended for a particular resident.
4. Demonstrate proper techniques in feeding and assisting to feed resident.
5. Describe and demonstrate facility procedure for computing resident intake during mealtime.

F. Principles of Observation and Reporting - 1 hour

1. Describe how to observe a resident for changes inconsistent with their normal behavior.
2. Describe how to report what is observed to the supervisory nurse.

Requirements of Paid Feeding Assistant Program

1. Feeding Assistant Program must be a minimum of eight (8) hours.
2. Feeding Assistant Program must be **State Approved**.
3. Each nursing facility must maintain a record of all individuals used as feeding assistants, who have successfully completed the training course for paid feeding assistants. The nursing facility must also have on file evidence that the individual has successfully completed a state approved program with the necessary competency to feed a resident.
4. Feeding Assistant Program must be coordinated, performed by and under the general supervision of a registered nurse or licensed practical nurse.
5. Feeding assistants must work under the supervision of a registered nurse (RN) or a licensed practical nurse (LPN) who is readily available.
6. A nursing facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
7. The nursing facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

State Approval Guidelines for Paid Feeding Assistant Programs

1. State approval is initiated by obtaining or requesting the South Carolina Core Curriculum for Paid Feeding Assistants, Requirements, and Guidelines from the Department of Health and Human Services' (DHHS) website at: **www.dhhs.state.sc.us** or by mail or fax. The below agreement must be read, signed, and maintained on record by the administrator/program coordinator of the feeding assistant program and the DHHS, Department of Facility Services representative. **This agreement shall remain in effect as long as the facility has a feeding assistant program.**

By signature of the authorized individual below, _____ (please insert the name of your facility/program) agrees to follow the South Carolina Feeding Assistant Core Curriculum and requirements. _____(please insert the name of your facility/program) understands and agrees that DHHS reserves the right to conduct announced or unannounced evaluations of our feeding assistant program at anytime.

_____ _____

Administrator/Coordinator Signature **Date**

_____ _____

Signature of DHHS Representative Acknowledging Receipt of Agreement **Date**