DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	12/30/10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-284	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[X] Prepare reply for appropriate signature DATE DUE 1/11/11
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

Back-up sent to Manager

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Linda B. Jennings, M.Ed., LPC
4 Carriage Lane Suite 100
Charleston, SC 29407

December 8, 2010

Emma Forkner
SCDHHS
P.O. Box 8206
Columbia, SC 29202-8206

Dear Emma Forkner:

After several times of trying I certainly hope that all the information certifying me as a provider is included. I am truly vexed by this whole process of getting approved to be a MEDICAID provider. I have worked with Dr. Robert Payne here at the Charleston Family Center for over 15 years providing counseling services for the indigent and abused children that had no where else to turn for assistance. Charleston Family Center has been a MEDICAID provider in good standing for well over 30 years; when few medical practioners accepted MEDICAID reimbursement we were there for our community.

I have a checklist sent to me on October 12, 2010 saying I was approved but shortly thereafter my whole packet was returned. Another instance concerns the disclosure of ownership, in one packet it was stamped Do Not Complete, then I get a Provider check off list saying it was a required document. I am not an owner of a business. I practice at Charleston Family Center, renting my office.

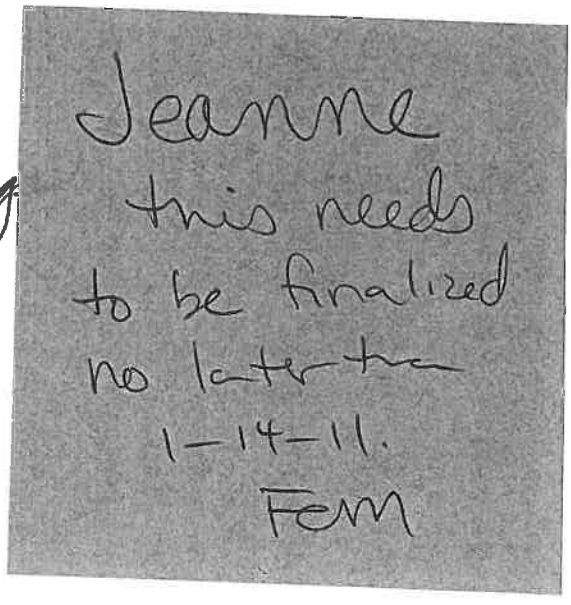
Since MEDICAID is in such dire straits I would think saving postage would be a priority.

If something else is missing would you be so kind to just ask for it and don't return my entire packet. I am truly exasperated.

Respectfully,

Linda B. Jennings

Linda B. Jennings, M.Ed., LPC



South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

Date: 1/4-10

Dear Medical Provider:

Medicaid Provider Enrollment is unable to process your request for enrollment at this time because:

____ An NPI Number was not applied to letter/W-9.

____ A required field(s) is not completed or is completed incorrectly. The appropriate field(s) is highlighted on the enrollment form, which is being returned to you at this time.

____ You are enrolling as a group provider and none of the individual numbers listed on the enrollment form are enrolled Medicaid providers and individual enrollment forms were not attached. Enrollment forms are enclosed.

____ You are currently being sanctioned by the Office of Inspector General, Centers for Medicare & Medicaid Services (CMS). You may reapply when you are reinstated.

____ You are currently not licensed/certified/permitted as required by Medicaid policy and procedures.

____ An Electronic Funds Transfer (EFT) Agreement was not returned with your enrollment form. This is a required document for enrollment processing.

✓ Electronic deposit information is required on bank letterhead. This is a required document for Electronic Funds Transfer (EFT). The information on bank letterhead must include: Name on Account, Electronic Routing Number, Account Number, Account Type and Bank Officer's Name and Signature.

OVER →

Medicaid Claims Control System
Medicaid Provider Enrollment
Post Office Box 8809, Columbia, South Carolina 29202-8809
(803) 264-1650 FAX (803) 699-8637

SLED CATCH

Citizens Access to Criminal Histories

Results

Name **Linda Jennings**
Date of Birth **1946 07 24**
Maiden Name **Bailey**
Gender **Female**
SSN
Transaction **004049143**
Date of Check **September 29, 2010 at 16:00**

NO ARREST DATA
IN ACCORDANCE WITH
SEARCH CRITERIA SUBMITTED
S.C. Law Enforcement Division
WWW

To Whom it may Concern:

The criminal history search was based upon the criteria furnished. It did not include a fingerprint comparison, which is the only means of positive identification. This **NO ARREST DATA** verification is only valid as of September 29, 2010 at 16:00 since a record may be established after that time. Therefore, if no action is taken within a reasonable period, it is recommended that another check be made.

Sincerely,

Reginald I Lloyd, Director.
South Carolina Law Enforcement Division

Credit Card Transaction Number **128579017 1ICE861100929155935**

Return | Another Check

New Search | Return to Search Form

Search Results:

0 hits from a national search including all states, territories and Indian Country for First Name like *Linda*, Last Name like *Jennings*. To view a list of the jurisdictions included in this search, click here.

New Search | Return to Search Form

South Carolina Sex Offenders

SOR Home

Search for Offender by Name	
Last Name (partial name accepted):	Jennings, Linda Bailey
Note: Name search is a SOUNDEx ("sounds like") search on both name and alias.	

Submit

While all attempts are made to provide complete and accurate information, the South Carolina Law Enforcement Division does not guarantee the accuracy of the information made available to the public via the South Carolina Sex Offender Registry Website. The information released through this site is as complete as has been currently verified and processed by registry personnel. It should be noted and understood that the information released via this site may be in the process of being verified and/or changed OR the listed offender may have changed information without notifying the registry personnel. If you feel the information is incorrect, please contact the Sheriff's Department in the county in which the sex offender is registered or SLED Sex Offender Registry at (803) 896-2601.

* - Each alias name stored on the SC SOR for an offender is listed

UID	SRS #	Name	Sex	Race
View Offender	4183	JENNINGS, BEN ALLEN	M	W
View Offender	5340	JENNINGS, DARGAN LUCIUS	M	W
View Offender	5340	JENNINGS, DARGON	M	W
View Offender	13005	JENNINGS, JAMES R JR	M	W
View Offender	13439	JENNINGS, JEFF ALLAN	M	W
View Offender	5833	JENNINGS, JOHN LELAND	M	W
View Offender	5354	JENNINGS, KEYAVONNIE	M	B
View Offender	5354	JENNINGS, KEYAVONNIE VALENTA	M	B
View Offender	5354	JENNINGS, KEYAVONNIE VELENTE	M	B
View Offender	5354	JENNINGS, KEYO	M	B
View Offender	5354	JENNINGS, KEYO V	M	B
View Offender	5354	JENNINGS, KEYO VALENTA	M	B
View Offender	5354	JENNINGS, KEYO VELATEA	M	B

View Offender	5354	JENNINGS, REYO V	M	B
View Offender	14847	JENNINGS, ROBERT CHARLES	M	W
View Offender	4469	JENNINGS, ROBERT LEE JR	M	B
View Offender	19143	JIMENEZ, LEONEL LAUREANO	M	W
View Offender	18773	JIMINEZ, FILEMON PEREZ	M	U

From: postmaster@isp.att.net
Subject: **Returned mail: delivery problems encountered**
Date: August 4, 2010 4:07:21 AM EDT
To: <lindabjenni@bellsouth.net>

A message (from <lindabjenni@bellsouth.net>) was received at 2 Aug 2010 20:25:53 +0000.

The following addresses had delivery problems:

info@scdhhshippa.org
Persistent Transient Failure: Unable to contact host for 1 days,
Delivery last attempted at 2 Aug 2010 20:25:53 +0000
Reporting-MTA: dns; isp.att.net
Arrival-Date: 2 Aug 2010 20:25:53 +0000

Final-Recipient: rfc822; info@scdhhshippa.org
Action: failed
Status: 4.4.7
Diagnostic-Code: smtp; (Persistent Transient Failure: Delivery time expired)
Last-Attempt-Date: 2 Aug 2010 20:25:53 +0000

From: Linda Jennnings <lindabjenni@bellsouth.net>
Date: August 2, 2010 4:25:52 PM EDT
To: info@scdhhshippa.org
Subject: LIP **enrollment**

I am a Licensed Professional Counselor. I have an NPI # and have read the manual for LIPs. I understand there is a
test which I am supposed to take on line next, however I cannot find it on the SC.Gov website. Please help! Linda B. Jennings

South Carolina Department of Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

Division of Family Services Checklist for LIP(s)

Provider Name: Linda Jennings	NPI #: 1871646315

YES	NO	Application must have the following:
✓		➢ Provider Type and Licensure
✓		➢ Attached Copy of current license issued in the State where business is conducted
✓		➢ Identified the Population to be served
✓		➢ Indicated that Office policies and procedures for emergency situations, confidentiality of records, consent for treatment, release of information, beneficiary's rights and responsibilities, record retention, Code of Ethics are on file
		➢ Other:

COMMENTS:

YES	NO	The following verification is attached:
✓		➢ Criminal Records Check (must be attached)
✓		➢ DSS Child Abuse and Neglect Registry Check
✓		➢ State Sex Offender Registry Check
✓		➢ National Sex Offender Registry Check
✓		➢ Professional Liability Coverage ($600,000)
✓		➢ General Liability Coverage ($600,000)
		➢ Automotive Liability Coverage ($600,000) If applicable
✓		➢ Worker's Compensation for South Carolina
		➢ Other:

COMMENTS:

DFS ACTION:			
Approved		Reviewed by: Toya Morgan (803) 898-2751	Date: October 12, 2010
YES	NO	Signature: Toya L Morgan	
✓			

COPY

Charleston Family Center, LLC
4 CARRIAGE LANE SUITE 100
CHARLESTON, SOUTH CAROLINA 29407
(843)763-2222 Fax (843) 766-5705

Fax Cover Sheet

From:
- ☐ Robert H. Payne, MD
- ☐ Anne Nason, MN, RN
- ☐ Linda Jennings, LPC

To: Linda

Date: 6/23

Fax No.:

No. of Pages (including cover):

Comments:

Linda, Typical Medicaid leaving everything to the very last minute

Julie

803 - 898 - 2565
Dept. of Fam. Svs.

Emma Forkner NPI # 1871646315

Emma Forkner
Off. of Dir.
803-898-2500

8/18/10
Toya Morgan
not on her list but am rsg. 10 days to send once they get ref. from her

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
June 22, 2010

Phys
OMP
MHRC

MEDICAID BULLETIN

TO: **Physicians, Psychologists, and Licensed Independent Practitioners of Behavioral Health**

SUBJECT: **I. On-Line Pre-Enrollment Orientation & Medicaid Enrollment**
II. Prior Authorization requirements for Licensed Independent Practitioners

On-Line Enrollment Orientation & Medicaid Enrollment

This information is a follow-up to the Medicaid Bulletin dated April 20, 2010. The South Carolina Department of Health and Human Services (SCDHHS), Division of Family Services, is responsible for the administration of optional State Medicaid Rehabilitative Behavioral Health Services (RBHS) for children and adults. Effective with dates of service on or after July 1, 2010, Medicaid enrollment is open to practitioners who are qualified to practice independently under South Carolina State Law as follows: Licensed Psychologists, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Independent Social Workers - Clinical Practice (CP) (with one year of documented experience). Psychologists currently participating in the Medicaid Program for Psychological Services for children under 21 will not need to re-enroll in the Medicaid program.

Licensed practitioners must have a National Provider Identifier (NPI) number to access the On-line Pre-enrollment Orientation. This training is limited to Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, and Licensed Independent Social Workers-CP. All Licensed Independent Practitioners (LIPs) may register for the on-line orientation at http://training.scdhhs.gov/academy. The orientation is available on-line twenty-four (24) hours a day, seven days a week. The orientation is intended to provide education about policy and procedure for rendering Medicaid RBHS and how to avoid potential recoupment of Medicaid payments.

Upon completion of the orientation, the LIP should be able to identify provider qualifications, Medicaid beneficiary eligibility requirements, covered services under RBHS, and basic documentation required for reimbursement.

LIPs must complete all fields of the on-line registration. All contact information submitted must be accurate. A Medicaid application and enrollment forms will be mailed to the LIP upon the successful completion of the orientation. Once the enrollment packet is returned to the address provided, the application and forms will be reviewed for all requested items/documentation. If a portion of the application/enrollment forms is not complete, the LIP will be contacted for additional information. The provider will be notified upon final approval of enrollment in the Medicaid Program.

If a LIP has been billing under a physician's NPI and has clients currently in treatment, he/she must directly enroll as a Medicaid provider and bill, for dates of service on or after July 1, 2010, directly for his/her services. In order to assure continuity of care for beneficiaries currently being seen through this arrangement, the LIP should complete the on-line orientation and enrollment process as quickly as possible.

II. Authorization of Services

All services provided through the LIP program must be medically necessary. In order to document medical necessity, a physician or, in the cases of a state agency referral, a Licensed Practitioner of the Healing Arts must complete a Medical Necessity Statement (MNS) PRIOR to the provision of any services. Failure to have medical necessity established PRIOR to the provision of services will result in the recoupment of payment.

If a physician, rather than a state agency, is referring the beneficiary for treatment, the MNS must be faxed to SCDHHS at (803) 255-8204, as well as be provided to the LIP for the beneficiary's record. For adult beneficiaries, the physician must also submit a completed SCDHHS LIP Authorization Form and a standardized behavioral health screening tool that validates the medical necessity. For beneficiaries under 21, the physician's completion of the MNS is adequate for the initial twelve (12) visits. It is expected that physicians will only refer beneficiaries who are active on their caseloads.

If the initial number of visits authorized is deemed by the provider as inadequate to address the identified goals, reauthorization of services will be required for both adults and children. Reauthorization requests must be sent in two weeks PRIOR to expiration of authorized visits. Failure to obtain reauthorization PRIOR to provision of services will result in denial or recoupment of payment. To request reauthorization of services for both adults and children, the physician must submit an updated, completed MNS, and an updated, completed SCDHHS LIP Authorization Form, and an updated standardized behavioral health screening tool that validates the medical necessity.

The SCDHHS MNS and SCDHHS LIP Authorization Forms are attached to this bulletin and should be submitted via fax to (803) 255-8204, attention LIP Program. Please ensure all sections are completed and signed by the referring physician. Failure to complete and submit all required documentation will result in delay/denial of reauthorization.

If you have any questions regarding this bulletin, please contact a Program Manager in the Division of Family Services at (803) 898-2565. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/S/
Emma Forkner
Director

EF/mwcj

Attachments

NOTE: Note: To receive Medicaid bulletins by email, please register at http://bulletin.scdhhs.gov/.
To sign up for Electronic Funds Transfer of your Medicaid payment, please go to
http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp and select "Electronic Funds Transfer" (EFT) for instructions.

South Carolina
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

FILL OUT COMPLETELY TO AVOID DELAYS/DENIALS

Client name:_____ Address_____ DOB_____

Medicaid ID #_____ Service Address Location:_____

Licensed Independent Practitioner (LIP) referred to: _____ Ind. NPI #:_____

Current clinical information: Make a selection below by circling the appropriate choice on the scale. 0=None 1=Mild 2=Moderate 3=Severe 4=Extreme

Aggression	0 1 2 3 4	Depression	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Abuse (PTSD)	0 1 2 3 4	Harm to self	0 1 2 3 4	Medical Illness	0 1 2 3 4
Anxiety Panic	0 1 2 3 4	Harm to others	0 1 2 3 4	Memory deficit	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Hallucinations	0 1 2 3 4	Sleep disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Impulsivity	0 1 2 3 4	Substance Abuse	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Other (note below)	0 1 2 3 4
Delusions	0 1 2 3 4	Mania	0 1 2 3 4	Current Stressors	0 1 2 3 4

If harm self or others, is there a plan: Yes or No (provide supporting documentation)

If other or current stressor listed as a 3 or 4 please list: _____

Psychiatric Hospitalization: Yes No If Yes indicate dates:

Treatment/Discharge Planning Goals:

(examples of treatments can include Behavior modification, client centered, CBT, Family Therapy, Interpersonal, Medication Management or Other. If other, please be specific and provide explanation below.

DSM IV TR: Diagnosis (es)	Goals:	Type of Treatment/ Interventions (see above)	Outcomes or Progress/Anticipated Discharge
Axis I	1.	1.	1.
Axis II	2.	2.	2.
Axis III	3.	3.	3.
	4.	4.	4.

Please complete if requesting additional visits.

Date last service: _____ Next Scheduled visit: _____ Frequency of visits _____
additional visits requested _____

Progress toward goals, outcomes, and additional comments: (Address each goal)

Please attach a copy of the standardized tool utilized as a means of supporting clinical impression, as well as most recent or up to date treatment plan/ progress note as an addendum along with any other pertinent progress notes to support the submission of claim information.

Referring MD Name: _____ Phone: ( ) _____ Fax ( ) _____
Please Print

Referring MD Signature: _____ Date: _____

MD Individual NPI# _____ MD Group NPI# _____

Treating Provider (LIP): _____ Individual NPI#: _____

Treating Provider (LIP) Phone: ( ) _____ Treating Provider (LIP) FAX: ( ) _____

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility benefit limitations, and provider compliance with all Medicaid requirements at the time services are rendered.

Division of Family Services
P.O. Box 8206 Columbia, South Carolina 29202-8206
(803) 898-2565 ^ Fax (803) 255-8204

South Carolina Department of Health & Human Services

MEDICAL NECESSITY STATEMENT FOR REHABILITATIVE SERVICES

Beneficiary's Name: _____ Social Security Number: _____

Date of Birth: _____ Medicaid Number: _____

Diagnosis code(s): _____
[Diagnosis codes must be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the International *Classification of Diseases (ICD).*]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or the ICD.

Indicate the specific Rehabilitative Service(s) being recommended on each line below.

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Rehabilitative Service(s): _____, _____, _____

Identify the Beneficiary's problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
(Signature of Physician or other Licensed Practitioner of the Healing Arts) (Professional Title)

_____ _____
(Please print name signed above) (Phone Number)

Signature Date: _____ (Services must be initiated within 45 calendar days.)
Must be handwritten

Note: The Referral/Authorization for Rehabilitative Services form (DHHS Form 254) and the MNS must be sent to the provider prior to the provision of services, or at the time the services are rendered.

Revised: 05/2010

DO NOT SEND

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

General Instructions

Federal Medicaid regulations (Title XIX – 42CFR 455.100 – 106) require that all Medicaid providers disclose the name and address of each person with an ownership or control interest in the provider and any subcontractor where the provider has a direct or indirect ownership interest of 5% or more. All applicants, except individual practitioners or group of practitioners as mentioned in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program.

Failure to provide this form may result in a refusal by the South Carolina Department of Health and Human Services (SCDHHS) to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

Please answer all questions as of the **current date**. If the **"Yes"** block for an item is checked, list the requested additional information in that item or under the **"Remarks"** section on page 4 if more space is needed, referencing the item number to which the information corresponds. If additional space is needed, use another sheet. Return the original to SCDHHS; retain a copy for your files.

Completion and submission of this form is also a condition of approval or renewal of a contractor agreement between the disclosing entity and SCDHHS. This form is to be completed under any programs established by Title XIX and Title XXI and must be submitted whenever any of the provider information changes. Any substantial delay in completing the form should be reported to SCDHHS.

I. Instructions / Definitions: Specify in what capacity you do business as (D/B/A); for example, trade name or corporation. Provider types that must have a NPI must include this information. If a valid telephone number is not included, this form will be returned and enrollment into the Medicaid program will not proceed.

I. Identifying Information			
[a] Name of Provider LINDA B. JENNINGS (D/B/A)			
Street Address 4 CARRIAGE LANE, SUITE 100		City, State, Zip + 4 CHARLESTON, SC. 29407	
County CHARLESTON	Provider Number	NPI Number	Telephone Number 843-763-2222
[b] Employer Identification Number (EIN), if applicable: N/A			
[c] Type of Entity (Applies to either For Profit or Non-Profit) N/A ☐ Limited Liability Corporation (LLC) ☐ Partnership ☐ Corporation ☐ Business Proprietorship or Company			

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.
Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. ***A disclosing entity*** is defined as a Medicaid provider, supplier, or other entity, other than an individual practitioner or group of practitioners, that furnishes services or arranges for furnishing services under Medicaid, Medicare, the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of

that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership interest*** means a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

II. Individuals and Organizations with Ownership and Controlling Interest

[a] List names, addresses, and social security numbers for individuals, or list names, addresses and the EIN for organizations, having direct or indirect ownership or a controlling interest, **as defined above,** in the entity listed in Section I. List any additional names and addresses under "Remarks" on page 4. If more than one individual is reported **and if any of these persons are related to each other**, this must be reported under "Remarks".

Name	Address	SSN	EIN
	N/A		

[b] Are any persons / entities with ownership or controlling interest in the provider also owners of other Medicare / Medicaid facilities? If yes, list name, address and NPI and/or EIN for each facility.
☐ Yes ☐ No

Name of Facility	Address	NPI	EIN
	N/A		

III. Instructions/ Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

III. If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and EINs for organizations under "Remarks" on page 4.

[a] Are there any individuals or organizations having a direct or indirect ownership or control interest of five (5) percent or more in the institution, agency, or organization (provider) that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, XX or XXI (Medicare, Medicaid, the Social Services Block Grant program or the State Children's Health Insurance Program [SCHIP])?

☐ Yes ☐ No N/A

[b] Are there any directors, officers, agents, or managing employees of the institution, agency, or organization (provider) who have ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, XX or XXI (Medicare, Medicaid, the Social Services Block Grant program or SCHIP)?

☐ Yes ☐ No N/A

Items IV-VII. Instructions/Changes in Provider Status:

Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership, the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any changes of ownership.

IV. If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
☐ Yes - Date: / / ☐ No ☐ Not Applicable

[b] Do you anticipate any change of ownership or controlling interest within the year?
☐ Yes - Date: / / ☐ No ☐ Not Applicable

N/A

V. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm or the name of the leasing organization and the EIN.

Is the facility operated by a management company or leased in whole or part by another organization?
☐ Yes ☐ No ☐ Not Applicable

If Yes, what are the dates of operation? Beginning Date / / to Ending Date / / .

Name	EIN

VI. List current managing employees by name, work telephone number, and Social Security number. "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations.
☐ Not Applicable

Name/ Title	Work Telephone	Social Security Number

VII. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

☐ Yes ☐ No ☐ Not Applicable

If Yes, give date for change: Date / / . List names, titles, and Social Security Number of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	Social Security Number

N/A

Item VIII. Instructions/ Definitions: A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, **are not** considered to be chain affiliates.

VIII. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and EIN of parent Corporation below.
☐ Yes ☐ No ☐ Not Applicable

Name	Address	EIN

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and EIN of parent Corporation.
☐ Yes ☐ No N/A

Name	Address	EIN

IX. (For facilities) Have you increased your bed capacity by ten (10) percent or more, or 10 beds, whichever is greater, within the last 2 years?
☐ Yes ☐ No
If Yes, give year of change: Current number of beds: Prior number of beds:

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH SCDHHS.

Name of Authorized Representative (Printed or Typed)	Title
LINDA B. JENNINGS	CLINICAL COUNSELOR
Signature: Linda B. Jennings	Date: 12/8/10

Remarks (Please attached additional sheet or other documentation if needed)

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

Date: 8/19/10

Dear Provider:

On behalf of the Department of Health and Human Services (DHHS), we would like to thank you for your interest in participating in the South Carolina Medicaid Program.

Enclosed you will find a Medicaid Enrollment Data form, a Disclosure of Ownership and Control Interest Statement form, a Trading Partner Agreement Enrollment form, an Electronic Funds Transfer (EFT) Authorization Agreement form and any other pertinent form(s) related to enrollment. All the forms need to be completed, signed, dated and returned to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

When your enrollment application is processed, you will be notified by letter. You will also receive further information regarding the Medicaid Program at that time.

If you have any questions or need additional information, please contact Medicaid Provider Enrollment at (803) 264-1650.

Sincerely,

Medicaid Provider Enrollment

Enclosures

MEDICAID PROGRAM TELEPHONE NUMBERS
AREA CODE 803

AMBULANCE SERVICES	898-2655
AMBULATORY SURGICAL CENTERS	898-2665
BEHAVIORAL HEALTH SERVICES	898-2565
LONG TERM CARE SERVICES	898-2590
CRNA SERVICES	898-2660
DENTAL SERVICES	898-2568
DURABLE MEDICAL EQUIPMENT SERVICES	898-2882
EARLY INTERVENTION & SCHOOL-BASED SERVICES	898-2655
ESRD SERVICES	898-2665
FQHC SERVICES	898-2660
HOME HEALTH SERVICES	898-2590
HOSPICE	898-2590
HOSPITAL SERVICES	898-2665
LABORATORY (INDEPENDENT AND X-RAY)	898-2660
MANAGE CARE SERVICES	898-4614
NURSE MIDWIFE SERVICES	898-2660
NURSING HOMES SERVICES	898-2590
OPTICIAN/OPTOMETRIST SERVICES	898-2660
OPTIONAL STATE SUPPLEMENTARY PROGRAM	898-2590
PHARMACY SERVICES	898-2876
PHYSICIAN SERVICES	898-2660
PSYCHOLOGIST (PH.D/MR/RD WAIVER ONLY)	898-2590
QUALIFIED MEDICARE BENEFICIARY PROGRAM	898-2565
SPEECH & HEARING SERVICES	898-2655
THERAPIES (PHYSICAL AND OCCUPATIONAL)	898-2655
THIRD PARTY LIABILITY	898-2630
TRANSPORTATION SERVICES	898-2655
MEDICAL SUPPORT SERVICES	898-4614

LISTED BELOW IS THE APPROPRIATE POST OFFICE BOX TO MAIL CLAIMS FOR PROCESSING AND PAYMENTS:

CMS 1500	POST OFFICE BOX 1412	COLUMBIA, SC 29202-1412
DENTAL	POST OFFICE BOX 2136	COLUMBIA, SC 29202-2136
UB-04	POST OFFICE BOX 1458	COLUMBIA, SC 29202-1458
PHARMACY	POST OFFICE BOX 8565	COLUMBIA, SC 29202-8565
HOSPITAL	POST OFFICE BOX 1458	COLUMBIA, SC 29202-1458
NURSING HOMES	POST OFFICE BOX 100122	COLUMBIA, SC 29202-1002
OPTIONAL STATE SUP.	POST OFFICE BOX 67	COLUMBIA, SC 29202-0067
ALL OTHERS	POST OFFICE BOX 8809	COLUMBIA, SC 29202-8809

SUBMIT MEDICARE CLAIMS TO:

MEDICARE CLAIMS PROCESSING UNIT
POST OFFICE BOX 100190
COLUMBIA, SC 29202-3190

South Carolina Department of Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

Date: 9-15-10

Dear Provider:

Thank you for your interest in becoming a South Carolina Medicaid provider for Rehabilitative Behavioral Health Services (RBHS). Enclosed you will find a Medicaid application for RBHS, Private Mental Health Medicaid Enrollment form and other pertinent forms related to enrollment. The forms must be completed and returned to the Division of Family Services (DFS) for review and approval. If any of the required documents are not submitted with the application or the application is incomplete, this will delay the enrollment process. Please return the application and all forms completed, signed and dated to:

SC Department of Health and Human Services
Division of Family Services – J9
Post Office Box 8206
Columbia, South Carolina 29202-8206

We strongly encourage you to carefully review the Medicaid Policy Manual for RBHS. The Policy Manual can be located at the DHHS web site at www.scdhhs.gov. In order to be reimbursed by Medicaid, all RBHS services must be Prior Authorized by an Authorized Referral Entity as designated by the South Carolina Department of Health and Human Services (SCDHHS). These entities are listed in the policy manual. Enrollment in the South Carolina Medicaid Program does not provide a guarantee of referrals or a certain funding level.

Please note that the Medicaid services for which you are being enrolled to render are optional Medicaid services. From time to time, the federal statutes and/or regulations governing this program may change. The Center for Medicare and Medicaid Services is the federal agency that has the final authority for interpretations, not SCDHHS. If at any time the Medicaid service(s) covered by this enrollment is not consistent with federal interpretation, this enrollment may be amended or terminated.

When your enrollment application is processed, you be notified by letter. You will also receive additional information regarding the Medicaid Program at that time.

If you have questions or need additional information, please contact the Division of Family Services at 803-898-2565.

Sincerely,

Jeanne Carlton

Jeanne Carlton, Director
Division of Family Services

Division of Family Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2565• Fax (803) 255-8204

South Carolina
Department of Health and Human Services

MAIL COMPLETED FORM TO:
DHHS- Behavioral Health Services - J9
Post Office Box 8206
Columbia, South Carolina 29202-8206

MEDICAID ENROLLMENT DATA
PRIVATE MENTAL HEALTH CENTERS

Enrollment Date: MO – DAY – YR

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE MEDICAID PROVIDER.
ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE BACK OF THIS FORM.

1 Medicaid No.

2 Provider Type: 10

3 1099 Indicator: Y

4 Sort Key

5 NAME OF GROUP

6 IRS Tax Payer Employer Identification Name (if different from name of group)

7 IRS EMPLOYER ID NO.

BUSINESS PRACTICE LOCATION ADDRESS (PHYSICAL LOCATION)

8 NUMBER AND STREET

9 CITY

10 STATE

11 ZIP + 4

Payment Address (If different from Business Practice Location Address)

12 In care of, Attention, Building Name, etc.

13 Number and Street or PO Box

14 City

15 State

16 Zip + 4

Mailing Address

17 Number and Street or PO Box

18 City

19 State

20 Zip + 4

21 COUNTY*

22 TELEPHONE (INCLUDE AREA CODE)

23 Type Ownership

24 EC Ind.: X

25 Medicare ID. No.

26 Practice Specialty: 20

27 NPI. NO

28 NPI ISSUE DATE

29 TAXONOMY CODE

30 Enroll Status

31 Enroll Date

32 NPI Type: T

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that I have read the conditions of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side of this form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid patient to release to SCDHHS medical information necessary for processing Medicaid claims.

Print Name and Title of Authorized Agent: _____

SIGNATURE AUTHORIZED AGENT: _____ Date _____
A facsimile stamp is not acceptable.

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number, which must be used in filing all claims.
- That services shall be provided to Medicaid recipients in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975 and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 1996. as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et. seq.) and its implementing regulation at 45 CFR Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That all fiscal and medical records shall be retained for a period of three (3) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the three (3) years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to the SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Department of Health and Human Services and/or their designee during normal business hours.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is limited by the Medicaid allowed amount for the service.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
- That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- Either party may terminate this agreement upon providing the other party with thirty (30) days written notice termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 Subpart B through 1001.1701 Subpart C (1999).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the Commission action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et. seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (1991), SHHSFC's regulation R.126-170, et seq., Code of Laws of South Carolina (1976) Volume 27 as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider must comply with all requirements of the Americans with Disabilities Act of 1990 (ADA), as applicable.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (42 CFR 165 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES) no later than May 23, 2007.
- Pursuant to the Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its NPI to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

COUNTY CODES (ITEM 21)

01	Abbeville	24	Greenwood
02	Aiken	25	Hampton
03	Allendale	26	Horry
04	Anderson	27	Jasper
05	Bamberg	28	Kershaw
06	Barnwell	29	Lancaster
07	Beaufort	30	Laurens
08	Berkeley	31	Lee
09	Calhoun	32	Lexington
10	Charleston	33	McCormick
11	Cherokee	34	Marion
12	Chester	35	Marlboro
13	Chesterfield	36	Newberry
14	Clarendon	37	Oconee
15	Colleton	37	Orangeburg
16	Darlington	39	Pickens
17	Dillon	40	Richland
18	Dorchester	41	Saluda
19	Edgefield	42	Spartanburg
20	Fairfield	43	Sumter
21	Florence	44	Union
22	Georgetown	45	Williamsburg
23	Greenville	46	York

60 Georgia within SC Svc. Area
61 Georgia outside SC Svc. Area
62 North Carolina within SC Service Area
63 North Carolina outside SC Service Area
64 Other

Penelope
9/24

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

Date: 9/17/10

Dear Medical Provider:

Medicaid Provider Enrollment is unable to process your request for enrollment at this time because:

___ Medicaid Number was not applied to letter/W-9.

___ A required field(s) is not completed or is completed incorrectly. The appropriate field(s) is highlighted on the enrollment form, which is being returned to you at this time.

___ You are enrolling as a group provider and none of the individual numbers listed on the enrollment form are enrolled Medicaid providers and individual enrollment forms were not attached. Enrollment forms are enclosed.

___ You are currently being sanctioned by the Office of Inspector General, Centers for Medicare & Medicaid Services (CMS). You may reapply when you are reinstated.

___ You are currently not licensed/certified/permitted as required by Medicaid policy and procedures.

___ Electronic Funds Transfer (EFT) Agreement was not returned with your enrollment form. This is a required document for enrollment processing.

✓ Electronic deposit information is required on bank letterhead. This is a required document for Electronic Funds Transfer (EFT). The information on bank letterhead must include Name on account, Electronic routing number, Account number, Account type and Bank officer's name and signature.

OVER →

Medicaid Claims Control System
Medicaid Provider Enrollment
Post Office Box 8809, Columbia, South Carolina 29202-8809
(803) 264-1650 FAX (803) 699-8657

____ W-9 was not returned with your enrollment form. This is a required document for enrollment processing.

____ The Disclosure of Ownership and Control Interest Statement Form (HCFA-1513 Modified by DHHS 10-97) was not returned with your enrollment form. This is a required document for enrollment processing.

____ The enrollment form is an out of date version. An updated enrollment form has been enclosed.

____ Effective July 1, 2006, all NEW or REACTIVATED enrollments require a National Provider Identifier (NPI), Zip plus four and Taxonomy. See enclosure for additional information regarding NPI.

____ The Centers for Medicare & Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) certificate was not returned with your enrollment form.

____ Other: NPI # listed on eft not on file. Please call # below to receive app to enroll with SC Medicaid

If you have any questions or need further information, please contact Medicaid Provider Enrollment at (803) 264-1650.

Sincerely,

Raushanna

Medicaid Provider Enrollment

Medicaid Claims Control System
Medicaid Provider Enrollment
Post Office Box 8809, Columbia, South Carolina 29202-8809
(803) 264-1650 FAX (803) 698-8657

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

Date: 10/15/10

Dear Medical Provider:

Medicaid Provider Enrollment is unable to process your request for enrollment at this time because:

____ Medicaid Number was not applied to letter/W-9.

____ A required field(s) is not completed or is completed incorrectly. The appropriate field(s) is highlighted on the enrollment form, which is being returned to you at this time.

____ You are enrolling as a group provider and none of the individual numbers listed on the enrollment form are enrolled Medicaid providers and individual enrollment forms were not attached. Enrollment forms are enclosed.

____ You are currently being sanctioned by the Office of Inspector General, Centers for Medicare & Medicaid Services (CMS). You may reapply when you are reinstated.

____ You are currently not licensed/certified/permitted as required by Medicaid policy and procedures.

____ Electronic Funds Transfer (EFT) Agreement was not returned with your enrollment form. This is a required document for enrollment processing.

____ Electronic deposit information is required on bank letterhead. This is a required document for Electronic Funds Transfer (EFT). The information on bank letterhead must include Name on account, Electronic routing number, Account number, Account type and Bank officer's name and signature.

OVER →

Medicaid Claims Control System
Medicaid Provider Enrollment
Post Office Box 8809, Columbia, South Carolina 29202-8809
(803) 264-1650 FAX (803) 699-8637

Dept. Head/ Program Rep. Jeanne Carlton

The enrollment/updating of this provider could not be completed due to the following problem(s):

_____ Authorized signature missing/signature not authorized for type.

_____ Provider already enrolled.
If the provider is already enrolled as a status 9 and the status is being changed to a 1 or 2, the new status and date must be entered on the form so that Provider Enrollment will know your intent. If you are changing the date only, complete both status and enrollment date fields and annotate that you only want the date changed.

_____ Date provider terminated/re-activation data conflict.
Need to remove the last terminated/conflicting status.

_____ Enrollment status and/or date is missing.

_____ Date of receipt missing at the top of the form.

_____ License #/issue date missing.

_____ Incorrect provider # entered/incorrect provider form completed.

_____ Provider name/number doesn't match (exactly as it appears in MMIS).

_____ Disclosure of Ownership and Control Interest Statement Form is: 1) Missing 2) Not Complete 3) Individual provider needs to complete & sign Cover Page 4) Group provider needs to complete & sign Pages 1-4.

_____ EFT Form/Bank Letter 1) Missing 2) Not Complete.

_____ Trading Partner Agreement (TPA) Enrollment Form 1) Missing 2) Not Complete.

_____ Rate Form: 1) Not complete 2) Not attached.

_____ W9 Form: 1) Missing 2) Not complete 3) Doesn't match enrollment.

_____ Field(s) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 30A, 31, 33, 34, 35, 36, 37 not complete.

_____ Verify CLIA data information.

✓ Other: need approved checklist

Thanks Lorette

Please return the completed/corrected form to Provider Enrollment.

Dept. Head/ Program Rep. Jeanne Carlton J-9

The enrollment/updating of this provider could not be completed due to the following problem(s):

_____ Authorized signature missing/signature not authorized for type.

_____ Provider already enrolled.
If the provider is already enrolled as a status 9 and the status is being changed to a 1 or 2, the new status and date must be entered on the form so that Provider Enrollment will know your intent. If you are changing the date only, complete both status and enrollment date fields and annotate that you only want the date changed.

RECEIVED
SEP 23 2010
DIVISION OF FAMILY SERVICES

_____ Date provider terminated/re-activation data conflict.
Need to remove the last terminated/conflicting status.

_____ Enrollment status and/or date is missing.

_____ Date of receipt missing at the top of the form.

_____ License #/issue date missing.

_____ Incorrect provider # entered/incorrect provider form completed.

_____ Provider name/number doesn't match (exactly as it appears in MMIS).

_____ Disclosure of Ownership and Control Interest Statement Form is: 1) Missing 2) Not Complete 3) Individual provider needs to complete & sign Cover Page 4) Group provider needs to complete & sign Pages 1-4.

_____ EFT Form/Bank Letter 1) Missing 2) Not Complete.

_____ Trading Partner Agreement (TPA) Enrollment Form 1) Missing 2) Not Complete.

_____ Rate Form: 1) Not complete 2) Not attached.

_____ W9 Form: 1) Missing 2) Not complete 3) Doesn't match enrollment.

_____ Field(s) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 30A, 31, 33, 34, 35, 36, 37 not complete.

_____ Verify CLIA data information.

✓ Other: Need bank letter individual name on eft, print name, need ~~Provider~~ checklist >
need Taxonomy code on enroll form.
Thanks, Laurie Adam

Please return the completed/corrected form to Provider Enrollment.

South Carolina Department of Health and Human Services

SEP 2 0 2010

MAIL COMPLETED FORM TO:
Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

INDIVIDUAL MEDICAID ENROLLMENT DATA 0263030
OTHER MEDICAL PROFESSIONALS

SEP 2 4 2010

Enrollment Date: MO – DAY – YR

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE MEDICAID PROVIDER.
ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.
ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE ATTACHMENT TO THIS FORM.

OCT 0 8 2010

1 Medicaid No.	2 Provider Type	3 1099 Indicator	4 Sort Key
	19	Y	

5 PROVIDER'S NAME: LINDA B. JENNINGS

6 PROVIDER'S SOCIAL SECURITY NO.: 269488151

OCT 13 2010

7 IRS Tax Payer Employer Identification Name (Sole Proprietor--ONLY)

8 IRS Employer ID No. (Sole Proprietor--ONLY)

BUSINESS PRACTICE LOCATION ADDRESS (PHYSICAL LOCATION)

9 NUMBER AND STREET: 4 CARRIAGE LANE SUITE 100

NOV 0 4 2010

10 CITY: CHARLESTON

11 STATE: SC

12 ZIP + 4: 29407-6048

Payment Address (If different from Business Practice Location address)

13 In care of, Attention, Building Name, etc.

14 Number and Street or PO Box

15 City

16 State

17 Zip + 4

Mailing Address

18 Number and Street or PO Box

19 City

20 State

21 Zip + 4

22 COUNTY*	23 TELEPHONE (INCLUDE AREA CODE)	24 Type Ownership	25 EC Ind.	26 Medicare ID No.
10	(843) 763-2222	002	X	

27 LICENSE NO.	28 LICENSE ISSUE DATE	29 STATE LIC. BOARD*	30 PRACTICE SPECIALTY (Enter Two Digit Code)
SC2625	09-20-91	40	PC

04 - Audiologist
06 - Certified Nurse Midwife/Licensed Midwife
25 - Certified Registered Nurse Anesthetist or Anesthetist Assistant
82 - Psychologist
84 - Speech Pathologist
85 - Physical Therapist
86 - Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant
87 - Occupational Therapist
LT - Licensed Marriage & Family Therapist
PC - Licensed Professional Counselor

31 Group Numbers: GP334 | 067670

If a member of a Group Practice, enter ID number assigned by Medicaid

32 CLIA Number	Cert. Type*	Effective Date	Expiration Date
		– –	– –

of CMS CLIA Certificate

29 NPI NO.	30 NPI ISSUE DATE	31 TAXONOMY CODE	32 Enroll Status	33 Enroll Date
1871646315	01-19-07	101YP2500X		1019 – –

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that I have read the conditions of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side of this form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid patient to release to SCDHHS medical information necessary for processing Medicaid claims.

Print Name and Title of Authorized Agent: LINDA B. JENNINGS, M.ED, LPC

SIGNATURE AUTHORIZED AGENT: Linda B. Jennings, M.Ed., LPC
A facsimile stamp is not acceptable.

Date 12/8/10

DHHS Form 219-GP (July 23, 2010)

CHARLESTON FAM. CTR.

South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name Linda B. Jennings

Medicaid Provider Number

Provider NPI Number 1871646315

Provider Address Charleston Family Center 4 Carriage Lane # 100

City Charleston State SC Zip 29407

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 Bank of America

Financial Institution Address

City State Zip

Routing Number (nine digit) 053904483

Account Number 7293447 79

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: Julie Roberts Phone Number: 843 763 2222

Signed [signature] *(Signature)*

(Print)

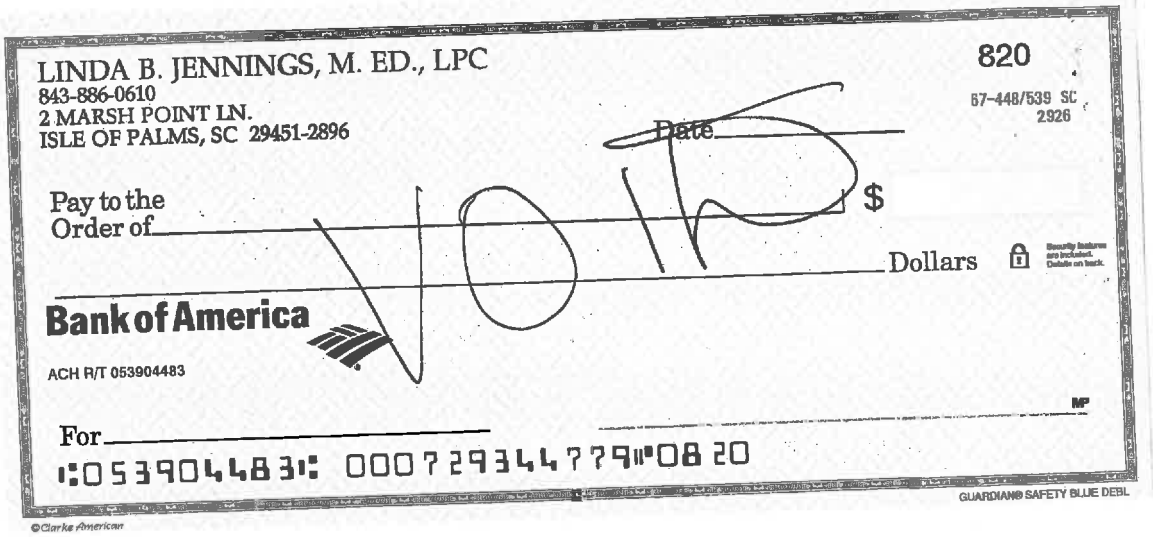
Title Office Manager Date 10/27/10

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 TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

EFT/Revised 01/09


LINDA B. JENNINGS, M. ED., LPC
843-886-0610
2 MARSH POINT LN.
ISLE OF PALMS, SC 29451-2896
820
67-448/539 SC
2926
Date
Pay to the
Order of
$
Dollars
Bank of America
ACH R/T 053904483
For
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Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
LINDA B. JENNINGS

Business name, if different from above

Check appropriate box: ☒ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
2 MARSH POINT LANE

Requester's name and address (optional)

City, state, and ZIP code
ISLE OF PALMS, SC 29451

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
269 48 8151

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ Linda B. Jennings | **Date** ▶ 9/8/10

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Bank of America

BANK OF AMERICA, N.A. (THE "BANK")

Direct Deposit Sign-Up Form

Directions

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2 and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

Section 1 (To be completed by Payee)

A. Name Of Payee (Last, First, Middle Initial)

LINDA B JENNINGS M ED

Address (Street, Route, P.O. Box, APO/FPO)

2 MARSH POINT LN

City | State | Zip Code

ISLE OF PALMS SC 29451-2896

Telephone Number

Area Code 843-884-7559

B. Name Of Person(s) Entitled To Payment

C. Claim Or Payroll ID Number

Prefix | Suffix

57-0732539

D. Type Of Depositor Account

☒ Checking ☐ Savings

E. Depositor Account Number

0007 2934 4779

F. Type Of Payment *(check only one)*

- ☐ Social Security
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Supplemental Security Income
- ☐ Mil. Active
- ☐ Railroad Retirement
- ☐ Mil. Retire
- ☐ Civil Service Retirement (OPM)
- ☐ Mil. Survivor
- ☐ VA Compensation or Pension
- ☒ Other (specify)

G. This Box For Allotment Of Payment Only *(if applicable)*

Type

Amount

Payee/Joint Payee Certification

I certify that I am entitled to the payment identified above and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

Signature	Date
Linda B Jennings	12/8/10
Signature	Date

Joint Account Holders' Certification *(optional)*

I certify that I have read and understood the back of this form, including the Special Notice to Joint Account Holders.

Signature	Date
Signature	Date

Section 2 (To be completed by Payee or Financial Institution)

Government Agency Name	Government Agency Address

Section 3 (To be completed by Financial Institution)

Name And Address

Bank of America
SC1-328-01-01
710 Coleman Boulevard
Mount Pleasant, SC 29464

Routing Number: 05390448

Check Digit: 3

Depositor Account Title: Linda B Jennings M ED

Financial Institution Certification

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with applicable federal regulations.

Print Or Type Representative's Name	Signature Of Representative	Telephone Number	Date
Bernadette Dewitt	Bernadette Dewitt	843 416 2564	12-8-2010

Financial institution should refer to the Green Book for further instructions.
The financial institution should mail the completed form to the Government agency identified above.

☐ Government Agency Copy ☐ Financial Institution Copy ☐ Payee(s) Copy

NSC
00-14-9109M 06-1999

Please Read This Carefully

All information on this form, including the individual claim number, is required under 31 USC 3332 and 31 CFR 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

Information Found On Checks

Most of the information needed to complete boxes A, C and F in
Section 1 is printed on your government check:
A. Be sure current address is shown.
C. Claim numbers usually printed on checks. Suffixes located beneath middle of claim number.
F. Type of payment usually beneath the amount.

Special Notice To Joint Account Holders
Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

Cancellation
The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. However, a cancellation by the financial institution for reasons of fraud shall be effective immediately. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

Changing Receiving Financial Institutions
The payee's direct deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the direct deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transaction is complete, i.e., after the new financial institution receives the payee's direct deposit payment.

False Statements Or Fraudulent Claims
Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

State of South Carolina
Department of Labor, Licensing and Regulation
Board of Examiners for Counselors, Therapists, & Psycho-Educational Specialists

Linda B Jennings, M.Ed.

Is Authorized to Practice as a
Licensed Professional Counselor

License Number 2625
Expires 08/31/2011

Administrator

INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT REGARDING REQUIRED DISCLOSURES

1. If you are a sole practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete the enclosed Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1513). Please sign below if you are enrolling as an individual practitioner and are exempt from these disclosure requirements.

Print or Type Name: LINDA B. JENNINGS

Signature: Linda B. Jennings

2. If you are exempt from providing the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1513), please respond to the following question:

Have you ever been convicted of a criminal offense in relation to the Medicaid, Medicare, or Title XX programs? (Conviction of a criminal offense is not a bar to enrollment as a Medicaid provider in all cases.)

☒ **No** ☐ **Yes**

If Yes, please list the charges, where you were convicted, the date, and disposition status of the conviction below.

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status

Please send this cover page with your completed Medicaid enrollment application. Do not send the attached Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit the attached Disclosure form.

Trading Partner Agreement Enrollment Form

Mail to: SC Medicaid TPA, P.O. Box 17, Columbia, SC 29202 or fax to (803) 870-9021

Date: 9/8/10

Action Requested: (Check One) ☒ New Trading Partner ID ☐ Change ☐ Cancel

Trading Partner Name: LINDA B. JENNINGS

Trading Partner ID: (If Applicable)

NPI: 1871646315 **Medicaid Provider No:**

Type of Business: (Check One) ☒ Medicaid Provider ☐ Clearinghouse ☐ Software Vendor ☐ Billing Service ☐ Other *(indicate)*:

Start Date: _____ (mm/dd/ccyy) **End Date:** _____ (mm/dd/ccyy) *(Required when canceling an account)*

South Carolina Medicaid Web Based Claims Submission Tool: ☐ # of IDs requested: _____

Protocol: (Check One) ☐ SecureFTP ☐ WS_FTP Pro ☐ CD ☐ Diskette

☒ **I have read, understand and agree with the conditions set forth in the South Carolina Medicaid Trading Partner Agreement for Electronic Claims and Related Transactions**

Signature: Linda B. Jennings

Print Name: LINDA B. JENNINGS

Software Vendor or Billing Agent:

Software Vendor or Billing Agent: JULIE ROBERTS

Contact Information:

Contact Name: As Above E-mail: dr424eknology-net

Phone: (843) 763 2222 Fax: (843) 766 5705

Transactions Requested

Transmission*	Y/N**		Transmission*	Y/N**	
ASC X12N 820 (004010X061A1)	☐		ASC X12N 834 (004010X095A1)	☐	
ASC X12N 270 (004010X092A1)	☐		ASC X12N 837I(004010X096A1)	☐	
ASC X12N 271 (009010X092A1)	☐		ASC X12N 837P(004010X098A1)	☐	
ASC X12N 276 (004010X093A1)	☐		ASC X12N 837D (004010X097A1)	☐	
ASC X12N 277 (004010X093A1)	☐		ASC X12N 835 (004010X091A1)	☐	
ASC X12N 278 (004010X094A1)	☐				

SC Medicaid EDI Help Desk Use Only	
Submitter ID:	**Date:**

REV. 11/06/2009