SECTION 4
ADMINISTRATIVE SERVICES

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SECTION 4 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The Department of Health and Human Services (DHHS) administers the South Carolina Medicaid Program. This section outlines the available resources for Medicaid providers, with telephone numbers, and addresses for county and regional DHHS offices.

CORRESPONDENCE AND INQUIRIES

All correspondence to the Medicaid administrative staff should be directed to:

Department of Health and Human Services
Attn: Integrated Personal Care Program Division
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-2590

Correspondence concerning specific policy and procedural problems must be directed to the appropriate program manager. Inquiries concerning specific claims should also be directed to the appropriate program manager, but only after corrections have been made on rejected claims and all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. Always include the provider's Medicaid number, the beneficiary's Medicaid number and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.** See the sample form at the end of this section.

Questions concerning beneficiary eligibility identification numbers should be directed to the DHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their respective county DHHS office for assistance. To verify eligibility status, please call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040.

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PROCUREMENT OF FORMS

FAX REQUESTS

A provider may request the following forms via fax number (803) 898-4528:

1. Confidential Medicaid Complaint (Form 126)
2. Medicaid Provider Inquiry (Form 140)
3. Request for Medicaid Forms (142)
4. Medicaid Refund Check Remittance (Form 205)

WEB ADDRESS

The most current version of this manual is available on the DHHS Web site at **www.dhhs.state.sc.us**.

To order a paper or CD version of this manual, please contact South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

PROGRAM-SPECIFIC FORMS

Providers should contact the DHHS regional nurse assigned to their area to order forms specific to the Integrated Personal Care Program.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES REGIONAL OFFICES

Aiken Counties: Aiken, Barnwell	2330 Woodside Executive Court Aiken, SC 29803 Telephone: (803) 641-7680 Fax: (803) 641-7682 1-888-364-3310
Anderson Counties: Anderson, Oconee	Post Office Box 5947 Anderson, SC 29623-5947 3215 Mall Road, Suite H Anderson, SC 29621 Telephone: (864) 224-9452 Fax: (864) 225-0871 1-800-713-8003
Charleston Counties: Berkeley, Charleston, Dorchester	5900 Core Road, Suite 505 N. Charleston, SC 29406 Telephone: (843) 529-0142 Fax: (843) 566-0171 1-888-805-4397
Columbia Counties: Fairfield, Lexington, Newberry, Richland	7499 Parklane Road, Suite 164 Columbia, SC 29223 Telephone: (803) 741-0826 Fax: (803) 741-0830 1-888-847-0908
Conway Counties: Georgetown, Horry, Marion, Williamsburg	Post Office Box 2150 914 Norman St. Conway, SC 29526 Telephone: (843) 248-7249 Fax: (843) 248-3809 1-888-539-8796

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DHHS REGIONAL OFFICES

Florence Counties: Darlington, Dillon, Florence, Chesterfield, Marlboro	201 Dozier Blvd. Florence, SC 29501 Telephone: (843) 667-8718 Fax: (843) 667-9354 1-888-798-8995
Greenville Counties: Greenville, Pickens	620 N. Main St. Greenville, SC 29601 Telephone: (864) 242-2211 Fax: (864) 242-2107 1-888-535-8523
Greenwood Counties: Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	617 S. Main St. Post Office Box 3088 Greenwood, SC 29648 Telephone: (864) 223-8622 Fax: (864) 741-0830 1-888-628-3838
Orangeburg Counties: Allendale, Bamberg, Calhoun, Orangeburg	1857 Joe S. Jeffords Highway Orangeburg, SC 29115 Telephone: (803) 536-0122 Fax: (803) 534-2358 1-888-218-4915
Point South Counties: Beaufort, Colleton, Hampton, Jasper	Highway 17 S. Post Office Box 2065 Ridgeland, SC 29936 Telephone: (843) 726-5353 Fax: (843) 726-5113 Beaufort Line: (843) 521-9191 1-800-262-3329
Rock Hill Counties: Chester, Lancaster, York	1890 Neely's Creek Road Rock Hill, SC 29732 Telephone: (803) 327-9061 Fax: (803) 327-9065 1-888-286-2078

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DHHS REGIONAL OFFICES

Spartanburg	1411 W. O Ezell Blvd., Suite 6 Spartanburg, SC 29301
Counties: Cherokee, Spartanburg, Union	Telephone: (864) 587-4707 Fax: (864) 587-4716 1-888-551-3864
Sumter	30 Wesmark Court Sumter, SC 29150
Counties: Clarendon, Kershaw, Lee, Sumter	Telephone: (803) 905-1980 Fax (803) 905-1987 1-888-761-5991

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DHHS REGIONAL OFFICES

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SECTION 4 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES COUNTY OFFICES

County	Telephone No.	Address
Abbeville County	(864) 366-5638	Medicaid Eligibility Abbeville County DSS Human Services Building 903 W. Greenwood St. Abbeville, SC 29620
Aiken County	(803) 643-1938	Medicaid Eligibility Aiken County DSS County Commissioner's Building 1410 Park Ave. S.E. Aiken, SC 29801
Allendale County	(803) 584-8137	Medicaid Eligibility Allendale County DHHS 611 Mulberry St. Allendale, SC 29810
Anderson County	(864) 260-4541	Medicaid Eligibility Anderson County DHHS 224 McGee Road Anderson, SC 29625
Bamberg County	(803) 245-4361	Medicaid Eligibility Bamberg County DHHS 374 Log Branch Road Bamberg, SC 29003
Barnwell County	(803) 541-1200	Medicaid Eligibility Barnwell County DSS T. Ed Richardson Building 10913 Ellenton St. Barnwell, SC 29812
Beaufort County	(843) 470-4625	Medicaid Eligibility Beaufort County DHHS 1905 Duke St. Beaufort, SC 29902

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DHHS COUNTY OFFICES

County	Telephone No.	Address
Berkeley County	(843) 719-1131	Medicaid Eligibility Berkeley County DSS 2 Belt Drive Moncks Corner, SC 29461
Calhoun County	(803) 874-3384	Medicaid Eligibility Calhoun County DHHS 2831 Old Belleville Road St. Matthews, SC 29135
Charleston County	(843) 792-0444	Medicaid Eligibility Charleston County DSS 326 Calhoun St. Charleston, SC 29403
Cherokee County	(864) 487-2521	Medicaid Eligibility Cherokee County DHHS 1434 N. Limestone St. Gaffney, SC 29340 Post Office Box 89 Gaffney, SC 29343
Chester County	(803) 377-8131	Medicaid Eligibility Chester County DHHS 115 Reedy St. Post Office Box 447 Chester, SC 29706
Chesterfield County	(843) 623-5226	Medicaid Eligibility Chesterfield County DHHS 202 N. Page St. Chesterfield, SC 29709
Clarendon County	(803) 435-4305	Medicaid Eligibility Clarendon County DSS 3 S. Church St. Manning, SC 29102

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DHHS COUNTY OFFICES

County	Telephone No.	Address
Colleton County	(843) 549-1894	Medicaid Eligibility Colleton County DSS Bernard Warshaw Building 215 S. Lemacks St. Walterboro, SC 29488
Darlington County	(843) 398-4420	Medicaid Eligibility Darlington County DHHS 300 Russell St., Room 145 Darlington, SC 29540-2077
	(843) 332-2289	404 S. Fourth St., Suite 300 Hartsville, SC 29550
Dillon County	(843) 774-2713	Medicaid Eligibility Dillon County DHHS 1213 Highway 34 W. Dillon, SC 29536
Dorchester County	(843) 563-9524	Medicaid Eligibility Dorchester County DSS 201 Johnson St., Bldg 17 Post Office Box 56 St. George, SC 29477
Edgefield County	(803) 637-4040	Medicaid Eligibility Edgefield County DSS 500 W. A. Reel Drive Edgefield, SC 29824
Fairfield County	(803) 635-5502 Ext. 425	Medicaid Eligibility Fairfield County DHHS 1136 Kincaid Bridge Road Post Office Box 1139 Winnsboro, SC 29180
Florence County	(843) 669-3354	Medicaid Eligibility Florence County DHHS 2685 S. Irby St., Box 1 Florence, SC 29505

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DHHS COUNTY OFFICES

County	Telephone No.	Address
Georgetown County	(843) 546-5134	Medicaid Eligibility Georgetown County DSS 330 Dozier St. Georgetown, SC 29440
Greenville County	(864) 467-7926	Medicaid Eligibility Greenville County DSS County Square 301 University Ridge, Suite 6700 Greenville, SC 29603
Greenwood County	(864) 229-5258	Medicaid Eligibility Greenwood County DSS 1118 Phoenix St. Greenwood, SC 29648
Hampton County	(803) 914-0053	Medicaid Eligibility Hampton County DHHS 102 Ginn Altman Ave. Hampton, SC 29924
Horry County	(843) 381-8260	Medicaid Eligibility Horry County DHHS 1601 11th Ave., 2nd Floor Conway, SC 29526
Jasper County	(843) 726-7747	Medicaid Eligibility Jasper County DSS 204 N. Jacob Smart Blvd. Ridgeland, SC 29936
Kershaw County	(803) 432-7676 Ext. 106	Medicaid Eligibility Kershaw County DHHS 110 E. DeKalb St. Camden, SC 29020
Lancaster County	(803) 286-8208	Medicaid Eligibility Lancaster County DHHS 200 E. Dunlap St. Post Office Box 2169 Lancaster, SC 29720

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DHHS COUNTY OFFICES

County	Telephone No.	Address
Laurens County	(864) 833-0100	Medicaid Eligibility Laurens County DSS Human Services Complex Industrial Park Road Laurens, SC 29361
Lee County	(803) 484-5376	Medicaid Eligibility Lee County DSS County Welfare Building 820 Brown St. Bishopville, SC 29010
Lexington County	(803) 957-2975 (803) 957-2991	Medicaid Eligibility Lexington County DHHS Social Services Center 541 Gibson Road Lexington, SC 29072
McCormick County	(864) 465-2627	Medicaid Eligibility McCormick County DSS 215 N. Mine St. Highway 28 N. McCormick, SC 29835
Marion County	(843) 423-5417	Medicaid Eligibility Marion County DHHS 200 Airport Court Mullins, SC 29574
Marlboro County	(843) 479-4389	Medicaid Eligibility Marlboro County DSS County Complex Ag St. Bennettsville, SC 29512
Newberry County	(803) 321-1255	Medicaid Eligibility Newberry County DSS County Human Services Center 2107 Wilson Road Newberry, SC 29108

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DHHS COUNTY OFFICES

County	Telephone No.	Address
Oconee County	(864) 638-4400	Medicaid Eligibility Oconee County DHHS 100 Brown Square Drive Post Office Box 979 Walhalla, SC 29691
Orangeburg County	(803) 531-3101	Medicaid Eligibility Orangeburg County DSS 2570 Old St. Matthews Road, N.E. Orangeburg, SC 29116
Pickens County	(864) 898-5815	Medicaid Eligibility Pickens County DHHS Social Services Building 212 McDaniel Ave. Post Office Box 160 Pickens, SC 29671
Richland County	(803) 714-7562 (803) 714-7549	Medicaid Eligibility Richland County DHHS 3220 Two Notch Road Columbia, SC 29204
Saluda County	(864) 445-2139	Medicaid Eligibility Saluda County DSS Highway 121 N. Saluda, SC 29138
Spartanburg County	(864) 596-2714	Medicaid Eligibility Spartanburg County DHHS Pinewood Shopping Center 1000 N. Pine St., Suite 23 Spartanburg, SC 29303 Post Office Box 4847 Spartanburg, SC 29305
Sumter County	(803) 773-5531	Medicaid Eligibility Sumter County DSS 105 N. Magnolia St., 4th Floor Sumter, SC 29151

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DHHS COUNTY OFFICES

County	Telephone No.	Address
Union County	(864) 429-1660	Medicaid Eligibility Union County DHHS 200 S. Mountain St. Post Office Box 1068 Union, SC 29379
Williamsburg County	(843) 355-5411	Medicaid Eligibility Williamsburg County DSS 831 Eastland Ave. Kingstree, SC 29556
York County	(803) 327-9061	Medicaid Eligibility York County DHHS 1890 Neely's Creek Road Rock Hill, SC 29730 Post Office Box 710 Rock Hill, SC 29731

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SECTION 4 ADMINISTRATIVE SERVICES

EXHIBITS

Form Number	Exhibit	Revision Date
	Application for Participation	
DHHS 2503	Annual Competency Evaluation Documentation	01/2003
DHHS 2504	IPC Personnel Competency Evaluation Form	01/2003
DHHS 2501	IPC Program Referral	11/2003
DHHS 2502	Consent Form	01/2003
DHHS 2505	IPC Service Care Plan Elements	01/2003
DHHS 2500	Sample Service Care Plan	01/2003
DHHS 175	IPC Service Provision Form	07/1992
DHHS 2507	Daily Task Log	01/2003
DHHS 2506	Daily Census Log	01/2003
	IPC Notification Form	
CRCF-01	Notice of Admission, Authorization & Change of Community Residential Care Facility	01/2003
DHHS 175-B	IPC Service Termination Notice	07/1994
	Health Insurance Referral Form	03/2004
DHHS 140	Medicaid Provider Inquiry	11/1987
DHHS 142	Request For Medicaid Forms And Publications	05/1997
	Authorization Agreement For Electronic Funds Transfer	11/2004
	Sample Turn Around Document (TAD)	
	Sample Remittance Advice	

APPLICATION FOR PARTICIPATION
Integrated Personal Care Services

1. A. _____
Name of Facility

B. _____
(Street Address or Location)

C. _____
(City) (County) (Zip Code) (Telephone Number)

D. Mailing Address if Different: (Fax Number) _____
_____
(City) (State) (Zip Code)

2. Facility License Number _____ (**Attach copy of facility license**)

3. A. Facility Administrator (Facility Contact)

_____ _____ _____
First Name MI Last Name

B. Administrator's License Number: _____ Expires: _____
(Attach copy of license issued by the Board of Long Term Health Care Administrators, Department of Labor, Licensing & Regulation.)

C. Does the Administrator have a high school diploma or equivalent?

☐ Yes (attach copy) ☐ No

D. Does the facility have a CLIA waver? If so, please attach a copy.

Please provide written documentation regarding supervisory management experience in a health care facility.

4. Name of responsible person in absence of administrator:

_____ _____ _____
First Name MI Last Name

5. Name of Licensed Nurse(s) on Staff

A. _____ ___ _____ _____
First Name MI Last Name License #

B. _____ ___ _____ _____
First Name MI Last Name License #

(Attach copy of license issued by the SC Board of Nursing) <u>Please use an additional sheet of paper if there are more names</u>

C. Number of other staff positions: Maintenance Workers____ Kitchen Staff ____
Custodians_____ Aides____ Other____

D. Do you have 24 hour awake aide? ☐ Yes _____ ☐ No
Number

6. Description of Facility:

a. Number of Licensed beds?_____

b. Location of Rooms

Name of Building	# of Resident Beds	# of Resident Bedrooms	# of Staff Beds	# of Staff Bedrooms	Total # of Beds in Building

c. Do you provide care for residents with Alzheimers Disease? ☐ Yes ☐ No

d. If yes, how many residents? _____

e. If yes, how many residents can you care for _____

f. Do you provide care for residents with mental illness? ☐ Yes ☐ No

g. If yes, do you have a Memorandum of Agreement with the SC Department of Mental Health ☐ Yes ☐ No

h. Do you contract with the S.C. Department of Mental Health to provide enhanced services? ☐ Yes ☐ No

7. A completed statement must be attached from a licensed professional attesting to the facility's compliance with the American's with Disabilities Act.

IPC Providers must have at a minimum:

- One working and accessible toilet on the accessible path,
- One fully functioning toilet for every 6 residents,
- One fully functioning and fully accessible toilet for every 6 physically impaired residents.

Please complete the following chart to identify the number of bathroom facilities available for use by residents. Bathrooms that include signage indicating they are limited to staff use or that require entrance into an administrative office for admittance may not be included.

Include information only on those bathrooms you consider to be fully accessible by any physically impaired and/or wheelchair bound residents.

Name of Building	Number of fully accessible, fully functioning bathroom(s)	Number of toilets in the accessible bathrooms	Number of shower/tubs in the accessible bathroom(s)

Bathrooms with Limited Accessibility

Name of Building	Number of bathrooms with limited accessibility	Number of toilets	Number of shower/tubs

(Attach drawing of layout of each building in the facility)

8. If any facility services or functions are located in buildings other than those named above, attach a description of the functions, locations, and addresses of buildings if different than Line 1.B.

9. If any other license held for any other activity at the location address identified on Line 1.A.?
☐ Yes ☐ No If yes, please explain_____
_____

10. Licensee (The legal entity who, or whose governing body, has the ultimate responsibility and authority for the conduct of the facility or service; the owner of the business; with whom rests the ultimate responsibility for maintaining approved applicable licensing standards for the facility.

A. _____

B. _____
(Mailing Address) (City) (State) (Zip Code)

C. Check one of the following characteristics in each of the three categories that applies to the licensee:

(1) ☐ Profit ☐ Not for Profit (Non Profit)

(2) ☐ State Government ☐ County Government ☐ District Government

☐ Religious ☐ Commercial ☐ None of these Categories apply

(3) ☐ Sole proprietorship ☐ Partnership ☐ Limited Partnership ☐ Corporation

☐ Limited Liability Corporation ☐ None in these categories apply

D. _____
(Complete title of licensee's governing body)

E. _____
(Name and title of presiding officer of governing body)

_____
(Mailing address of presiding officer)

_____
(City) (State) (Zip Code) (Telephone Number)

11. Real property ownership. Is the land and/or building on/in which the facility or service is conducted owned by the licensee? ☐ Yes ☐ No If no, attach a list of providing information similar to that required in Line 8, above.

12. Management. Has the licensee engaged an entity other than an employee of the licensee to manage or operate the facility? ☐ Yes ☐ No If yes, attach a list providing information similar to that required in Line 8, above.

13. Is there any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information and/or provided. ☐ Yes ☐ No

14. SIGNATURE(S)

I, _____ and _____ have read the forgoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief.

_____ _____
(Signature) * (Title)

_____ _____
(Signature)* (Title)

*An application must be signed by the owner if an individual; or in the case of a limited liability corporation, the head of the limited liability corporation; or two of the owners if a partnership; or, in the case of a corporation, by two of its officers; or, in the case of a governmental unit, by the head of the governmental department having jurisdiction over the facility.

15. _____ _____ _____
Name and title of person preparing this application (Telephone Number) Date Prepared

Integrated Personal Care Services
Application Supplement

In addition to filling out the application to participate in the IPC program, below are several documents that must be attached with the application.

- ☐ Copy of the facility license
- ☐ Copy of the administrators license
- ☐ Copy of the administrators high school diploma or equivalent
- ☐ Copies of nurses license
- ☐ Facility Accessibility Checklist
- ☐ Facility's response to the most recent survey
- ☐ Most recent survey report
- ☐ W-9 (Tax form)
- ☐ Copy of the CLIA Waiver
- ☐ Layout of drawing of the facility

Forms to attach if applicable
MOA w/DMH
Contract w/DMH to provide enhanced services

Please return the completed forms to
Attention:
IPC Program Assistant
SC Dept of Health & Human Services
Integrated Personal Care Program
PO Box 8206
Columbia, SC 29202-8206

ANNUAL COMPETENCY EVALUATION DOCUMENTATION

Required Training/Evaluation For Unlicensed Staff Providing or Supervising Care

Trainee's Name _____ SS# _____
LPN or RN Conducting Training/Evaluation _____

AREA EVALUATED	SATISFACTORY/UNSATISFACTORY	DATE	NURSE INITIALS
Handwashing and basic infection control procedures			
Assisting the resident with dressing			
Assisting the resident with transferring			
Assisting the resident with ambulation			
Assisting the resident with bathing			
Assisting the resident with personal grooming			
Assisting the resident with toileting			
Assisting the resident to eat			
Providing incontinence care			
Providing a bed bath			
Taking and recording vital signs			
Addressing behavioral symptoms			
Observing, recording and reporting tasks			
Identifying and reporting problems/changes			

If additional training was required on any of the above components, document below the instruction provided and the date(s) retested.

_____

_____

_____

Statement to Nurse Trainers

Staff training and evaluation must be completed prior to IPC service delivery and annually thereafter. It is the responsibility of the IPC facility to ensure that IPC resident aides and the supervising staff are competent to perform the tasks identified in the Service Care Plan of each IPC resident. The facility administrator and /or any staff person with daily supervisory responsibilities for the IPC resident aids must also be trained. Evidence of training/evaluation must be maintained in personnel records by the IPC service provider and made available to DHHS staff upon request. The training/evaluation for IPC is in addition to the annual training requirements for licensure by DHEC. For additional information, please call your regional DHHS IPC nurse.

Signature of RN or LPN _____ Date _____

DHHS Form 2503 (Jan 03)

INSTRUCTIONS: SCDHHS IPC FORM 2503

ANNUAL COMPETENCY EVALUATION DOCUMENTATION

PURPOSE: This is a form to validate competency of staff in skills or tasks necessary for the provision of IPC services.

ITEM BY ITEM INSTRUCTIONS:

1. **Name of Personal Care Aide or Supervisor:** Enter name of trainee. All IPC aides and supervisors must be assessed as competent in tasks or skills that are necessary for providing IPC services
2. **Area Evaluated:** All skills/tasks listed must be evaluated.
3. **S/U:** Indicate with an S for satisfactory performance or U for unsatisfactory performance for each task or skill evaluated. Any additional training or retesting should be indicated in the lined space provided below the Table.
4. **Date:** Enter date that skill or task was evaluated.
5. **Initials of Nurse:** RN or LPN that conducted evaluation enters her/his initials.
6. **Signature:** Full signature, and title (RN OR LPN) of nurse(s) conducting the evaluation signify that evaluation was completed in compliance with written Statement to Nurse Trainers.

SUBSTITUTION OF ANOTHER FORM: Another staff training or competency evaluation form can be used provided it was approved as part of the facility's IPC Policies and Procedures.
FILING: This form should be retained at the facility with other staff training documents.

Integrated Personal Care (IPC)

PERSONNEL COMPETENCY EVALUATION FORM

Name of Resident Assistant or Supervisor _____

---------- Skills or Tasks ----------	----S/U ----	-- ---Date-----	Initials of Nurse

S=Satisfactory Performance
U=Unsatisfactory Performance

Place a full signature to correspond with each set of initials appearing above.

Initials	Corresponding Signature of Nurse	Title

INSTRUCTIONS: SCDHHS FORM 2504

PERSONNEL COMPETENCY EVALUATION DOCUMENTATION

PURPOSE: This is a form to validate competency of staff in skills or tasks necessary for the provision of IPC services. Tasks or skills not listed on the Annual Competency Evaluation Form that are necessary to deliver IPC or other services identified in the service care plan must be specified.

ITEM BY ITEM INSTRUCTIONS:

7. **Name of Personal Care Aide or Supervisor:** Enter name of trainee. All IPC aides and supervisors must be assessed as competent in tasks or skills that are necessary for providing IPC services
8. **Area Evaluated:** List skills/tasks to be evaluated.
9. **S/U:** Indicate with an S for satisfactory performance or U for unsatisfactory performance for each task or skill evaluated. Any additional training or retesting should be indicated in the lined space provided below the Table.
10. **Date:** Enter date that skill or task was evaluated.
11. **Initials of Nurse:** RN or LPN that conducted evaluation enters her/his initials.
12. **Signature:** Full signature, and title (RN OR LPN) of nurse(s) conducting the evaluation signify that evaluation was completed in compliance with written Statement to Nurse Trainers.

SUBSTITUTION OF ANOTHER FORM: Another staff training or competency evaluation form can be used provided it was approved via the IPC policies and procedures.

FILING: This form should be retained at the facility with other staff training documents.

IPC PROGRAM REFERRAL

RESIDENT NAME:		**ROOM#:**
CURRENT ADDRESS:		
Street:		
City:	**State:**	**Zip Code:**
County:		
Mailing Address:		
City:	**State:**	**Zip Code:**
Phone#: ( )	**Date of Birth:**	
SS#:	**Medicare#:**	
Medicaid#:		

FACILITY INFORMATION

Facility Name:		**Provider ID#:**
Address:		**Phone#:**
City:	**State:**	**Zip Code:**

RESPONSIBLE PARTY INFORMATION

Name:	**Relationship:**	
Address:		
City:	**State:**	**Zip Code:**
Phone#: ( )	**2nd Phone#:**	

RESIDENT STATISTICAL INFORMATION

Marital Status:	**Race:**	**Sex: M ☐ F ☐**
Primary Language: ENGLISH ☐ SPANISH ☐ OTHER _____		

RESIDENT DEFICIENCIES (CHECK)

LOCOMOTION ☐ DRESSING ☐ TOILET USE ☐ TRANSFER ☐

INCONTINENT ☐ EATING ☐ BATHING ☐

Cognitive Impairment/Diagnosis:

Is Resident Aware of Referral: YES ☐ No ☐

If No, Please Explain:

_____

Person Making this Referral:	**Phone#: ( )**

PHYSICIAN INFORMATION

PRIMARY PHYSICIAN:

Address:

CITY:	**State:**	**Zip Code:**

Phone#: ( )

FAX THIS COMPLETED FORM AND SIGNED CONSENT TO: (803) 255-8209

DHHS Form 2501 (11/03)

SOUTH CAROLINA INTEGRATED PERSONAL CARE PROGRAM

CONSENT FORM

Resident Name: _____

Social Security Number: _____

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

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals, organizations and facility staff members involved with my care; and,
c. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses or other medical personnel or medical facilities involved in my care to release to the South Carolina Integrated Personal Care Program any medical information regarding my diagnosis, functional abilities and recommended treatment.

I hereby authorize the South Carolina Integrated Personal Care Program to release information on my behalf to the following: physicians, hospitals, health and human service organizations, health and human service agencies, family members, the residential care facility and/or other persons directly involved with my care.

I understand that if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the Statewide Alzheimer's Disease and Related Disorders Registry, and that I or my responsible party may be contacted for additional information. Also, if an extraordinary situation should arise, I understand that photographs may be taken and used to document suspected problems.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information.

This consent shall remain in effect for one year from the date the consent is signed or until revoked by me in writing, or until such time as my case is closed by the Integrated Personal Care Program.

_____ _____
Date Signature of Client or Responsible Party

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

_____ _____
Date Signature of Witness

Facility _____

Resident _____

Medicaid ID #_____

IPC Service Care Plan Elements

Date & Sign	Problem	Goal/Objective	Target Date	Tasks	Date Achieved

INSTRUCTIONS: DHHS IPC Service Care Plan Elements

PURPOSE: This form contains the elements that are to be incorporated into the individualized service care planning document on each IPC resident which directs the provision of personal care. The plan is developed and signed by a registered nurse.

ITEM BY ITEM INSTRUCTIONS:

1. **Facility Name:** Enter the name of the CRCF.
2. **Resident:** Enter the name of the resident.
3. **Medicaid ID #:** Enter the Medicaid identification number of the resident.
4. **Date and Sign:** Enter the date when the plan is developed and provided signature.
5. **Problem:** Clearly defined, addressing dependencies/impairments identified on the SCDHHS Form 1718.
6. **Goal:** A positive, measurable statement of what is to be achieved.
7. **Target Date:** Date for expected resolution of the problem.
8. **Tasks:** Enter tasks that may be assigned to IPC facility aides.
9. **Date Achieved:** Enter the date when the registered nurse evaluates whether or not the problem was resolved.

NOTE:

1. Service Care Plan practices shall be in compliance with Individual Care Plan Standards set forth in Section 703 of the DHEC Standards for Licensing Community Residential Care Facilities, Regulation Number 61-84.

2. Dependencies or impairments identified in the IPC assessment must be addressed in the service care plan.

REVISIONS: The service care plan must be revised by the registered nurse at least every six months and more frequently if changes in the resident's condition necessitate a change in the plan of care.

SUBSTITUTION OF ANOTHER FORM: The Service Care Plan elements can be incorporated into an existing care plan format.

FILING: The service care plan must be maintained in the permanent record of the resident and be available to all staff that provide care to the residents. The initial service care plan should be faxed/mailed to the regional DHHS nurse for approval. Subsequent service care plans will be reviewed by the DHHS nurse on site visits.

Service Care Plan

Facility _____

Resident _____

Date & Sign	Problem	Goal/Objective	Target Date	Tasks	Date Achieve
6/19/02	1) Incontinence of urine during sleeping hours	Be continent at all times.	8/19/02	1) No fluids after 8 PM 2) Assist to bathroom just before bedtime 3) Awaken at 6AM. and assist to bathroom. 3) Record incontinence on daily log 4) Avoid using adult pads/briefs 5) Offer to assist to toilet every 2 hours during awake hours	
6/19/02	2) Lack of interest in daily activities	1) Demonstrate an increased interest in self-care activities by getting up in the morning without being prompted more than once.	8/19/02	1) Assist in laying out clothing the night before. 2) Before bedtime talk with resident about the next day's activities 3) List things the resident says they enjoy doing 4) Attempt to have meaningful activities for the resident to engage in.	

Integrated Personal Care
Service Provision Form

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

TYPE OF AUTHORIZATION:
New

From: IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206

AUTHORIZATION IS HEREBY GIVEN TO PROVIDE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.

Service(s) Authorized: IPC Waiver Services

IPC PROCEDURE CODE: _____

Authorized Start Date: _____

Authorized End Date: _____ (if applicable)

Comments:

Total Units Authorized: 7 Sun 1 Mon 1 Tue 1 Wed 1 Thur 1 Fri 1 Sat 1

CLIENT INFORMATION

NAME		BIRTHDATE	SEX
ADDRESS			
TELEPHONE NO.	IPC CLIENT NO.	SOCIAL SEC NO.	MEDICAID NO.	ELIGIBILITY TYPE

RESPONSIBLE PARTY

NAME		
ADDRESS		
RELATIONSHIP	HOME TELEPHONE	WORK TELEPHONE

Physician: _____

Directions to client's home:

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

SCDHHS FORM 175 JUL 92

Division of Community and Facility Services
Integrated Personal Care Program

DAILY TASK LOG

Month/Year _____

TASK	HOUR	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	31
Diet ☐ G-good 75% F-fair 50% P-poor 25% R-refused S_____ A_____ T_____	Break																															
	Lunch																															
	Dinner																															
	Snack																															
Bathing ☐ S-shower T-tub P-partial S_____ A_____ T_____																																
Dressing ☐ S_____ A_____ T_____																																
Locomotion ☐ W-walks WA-walker WC-wheelchair C-cane S_____ A_____ T_____																																
Transfer ☐ S_____ A_____ T_____																																
Toileting ☐ T-toileting program D-pads or briefs S_____ A_____ T_____																																
Bladder ☐ C-continent I-incontinent S_____ A_____ T_____																																
Bowel ☐ C-continent I-Incontinent S_____ A_____ T_____																																
Behavior ☐																																
Weight ☐ Monitor _____																																
Vital Signs ☐ Monitor _____Blood Pressure																																
_____ Temperature																																
_____ Pulse																																
_____ Respirations																																
Aide's Initials																																
Weekly Monitor Nurse Signature/Date																																

Resident's Name	**Room/Bed Number**	**Medicaid Number**

Key S–Self/Resident completes independently
A-Assisted by caregiver, T-Total care by caregiver

NAME OF CRCF _____

PROVIDER NUMBER_____

Initials	Signature	Initials	Signature

INSTRUCTIONS: SCDHHS IPC FORM 2507
DAILY TASK LOG
PURPOSE: This is a form to indicate the amount of assistance a resident is requiring on a daily basis that is kept for the entire month.

ITEM BY ITEM INSTRUCTIONS:

At the top:

1. Month/year: Enter the current month and the current year that these activities are taking place.
2. Diet: Enter for each day of the month, the letter for the amount of food consumed for each meal and check the amount of assistance that was required for them to eat.
3. Bathing: Enter the type of bath the resident required and check the level of assistance needed.
4. Dressing: Enter the amount of assistance given.
5. Locomotion: Enter how the resident locomotors and check the amount of assistance given to complete this activity.
6. Transfer: Enter/check the amount of assistance given.
7. Toileting: Enter if the resident receives a toileting program or uses pads/briefs.
8. Bladder: Enter whether the resident is continent or incontinent for each day, then check the amount of assistance given to the resident for cleanup.
9. Bowel: Enter whether the resident is continent or incontinent, then check the amount of assistance that is given for cleanup.
10. Behavior: Enter the daily resident's behavior.
11. Weight: Enter how often the weight is monitored, then place the weight in the appropriate days box.
12. Vital Signs: Enter/check which vital sign is taken and how often by "Monitor" then place the vital sign recording in the appropriate days block.
13. Aide's Initials: Enter the initials of the aide providing majority of personal care each day.

At the bottom:

14. Weekly Monitor Nurse Signature/Date: The licensed nurse will sign and date the weekly review for completion of the form.
15. Resident's Name: Enter the name of the resident that the log is being kept for.
16. Room/Bed Number: Enter which room and bed the resident is in.
17. Medicaid Number: Enter the resident's Medicaid identification number.
18. Name of CRCF: Enter the name of the facility.
19. Provider Number: Enter the facility's Medicaid provider number.

Back of Form, Top Section:

20. Initial/Signature: Any aide documenting on the form must place initials and corresponding signature in this Section.

SUBSTITUTION OF ANOTHER FORM: Another Personal Care Log or Record can be used provided that there is a record initialed daily by the aide assisting the resident with Activities of Daily Living and that a licensed nurse must record monitoring for completeness weekly.
FILING: This record is to be maintained in each resident's chart for the period of time as required by DHEC Regulation 61-84.

DIVISION OF COMMUNITY AND FACILITY SERVICES
Optional State Supplementation
Integrated Personal Care

DAILY CENSUS LOG

Name of Facility	Provider ID No.	Month/Year

OSS or IPC	W/C	-----Name of Resident-----	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	31

Codes
I = IPC Participant
O = OSS only
W/C = wheelchair

Codes for Calendar
A = Admission
√ = Present
D = Discharge
D = Discharge
PL = Personal Leave
HL = Hospital Leave

This is to certify that this is a correct daily census of all residents for the month/year of _____.

_____
Signature/ Facility Administrator/Designee Date

THIS IS A TWO-SIDED FORM
DHHS FORM 2506 (JAN 03)

INSTRUCTIONS: SCDHHS IPC FORM: DAILY CENSUS LOG

PURPOSE: This is a form to indicate on a daily basis the location and type of residents at the CRCF.

ITEM BY ITEM INSTRUCTIONS:

1. **Name of Facility:** Enter the name of the CRCF.
2. **Provider ID Number:** Enter the assigned OSS Provider number.
3. **Month and Year:** Enter the month and year of the reporting period.
4. **OSS or IPC:** For a resident enrolled in the IPC Program enter an "I"; for residents only receiving OSS enter an "O". If not in IPC or OSS, leave blank.
5. **W/C:** For a resident that has used a wheelchair during the month, enter a w/c in the block preceding the resident's name.
6. **Name of Resident:** Enter the names of all residents at the CRCF during the month of the reporting period.
7. **Calendar Days 1 – 31:** Using the "Codes for Calendar" at the bottom of the form, use checkmarks to indicate residents at the CRCF and use the other designated abbreviations as indicated.
8. **Signature and Date:** The facility administrator or designee dated signature certifies the correctness of the form.

SUBSTITUTION OF ANOTHER FORM: Another daily census form or monthly roster of residents can be used in place of this form provided the substituted form can be altered to provide the information requested.

FILING/SUBMISSION OF FORM: The original of this form should be maintained at the CRCF; a copy should be mailed/faxed to the IPC Central Office by the 10th of the following month. Address and Fax are as follows:

IPC Program
Attention: IPC Program Assistant
SC Dept of Health & Human Services
PO Box 8206
Columbia, SC 29202-8206

FAX: (803) 255-8209

INTEGRATED PERSONAL CARE NOTIFICATION FORM

TO:

FROM:

IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206
(803)898-2590

Client: SSN#: MA#:

- Comments: Comments in this section would relate to specific resident status in the IPC Program.

IPC Signature:_____ Date:_____

COPIES SENT TO:

[ ] Client
[ ] LTC Facility
[ ] County DSS
[ ] Caregiver/Responsible Party
[ ] Hospital
[ ] Physician
[ ] Other

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OPTIONAL STATE SUPPLEMENTATION & INTEGRATED PERSONAL CARE PROGRAMS
NOTICE OF ADMISSION, AUTHORIZATION & CHANGE OF STATUS FOR COMMUNITY RESIDENTIAL CARE FACILITY

SECTION 1 – IDENTIFICATION OF PROVIDER AND RESIDENT

1. RESIDENTS NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE _____ | _____ | ____ (MO.) (DAY) (YR.)	2. RESIDENTS MEDICAID I.D. NUMBER __ __ __ __ __ __ __ __ __ __
4. RESIDENTS ADDRESS	5. COUNTY NAME	6. SOCIAL SECURITY NO. __ __ __ |__ __ | __ __ __ __
7. CRCFS NAME & ADDRESS (ST. NAME, CITY, STATE)	8. CRCFS I.D. #	9. DATE OF REQUEST __ __ | __ __ | __ __ (MO.) (DAY) (YR.)

SECTION II – ADMISSION, INCOME, TRANSFER, TERMINATION OR CHANGE IN STATUS

* (A) ADMITTED TO THIS CRCF ON _____
(MO.) (DAY) (YR.)

(B) AUTHORIZATION TO BEGIN PAYMENT _____
(MO.) (DAY) (YR.)

(C) RESIDENTS COUNTABLE INCOME EFFECTIVE: _____ $ _____ $_____
(MO.) (YR.) AMOUNT PERSONAL NEEDS AMOUNT

(D) TRANSFERRED TO ANOTHER CRCF _____ _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY COUNTY

* (E) TERMINATION/DISCHARGE _____ IF DECEASED, SPECIFY DATE OF DEATH _____
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS _____

_____

_____

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

SECTION III – ABSENCES

(A) ADMITTED TO A NURSING FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(B) ADMITTED TO A MEDICAL INSTITUTION OR MENTAL HEALTH FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(C) READMITTED FROM A MEDICAL INSTITUTION, MENTAL HEALTH FACILITY OR NURSING FACILITY _____ _____
(MO.) (DAY) (YR.) NAME OF FACILITY

(D) TEMPORARY MEDICAL ABSENCE – BEGINNING _____ ENDING_____
(MO.) (DAY) (YR.) (MO.) (DAY) (YR.)

(E) TEMPORARY NON-MEDICAL ABSENCES – BEGINNING _____ ENDING _____
(MO). (DAY) (YR.) (MO). (DAY) (YR.)

_____ _____
AUTHORIZED ELIGIBILITY WORKER SIGNATURE DATE

_____ _____
AUTHORIZED COMMUNITY RESIDENTIAL CARE FACILITY SIGNATURE DATE

Integrated Personal Care
Service Termination Notice

PROVIDER: VERIFY
MEDICAID ELIGIBILITY MONTHLY

From: IPC Program
P.O.Box 8206
7th Floor Suite
Columbia, SC 29202-8206

AUTHORIZATION IS HEREBY GIVEN TO TERMINATE THE FOLLOWING SERVICE(S) UNDER YOUR CONTRACT WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PROVISION THEREOF.

Service(s) Authorized: _____ IPC PROCEDURE CODE: _____

Authorized Start Date: _____ Authorized End Date: (if applicable) _____

Reason for Termination: _____

Total Units Authorized: 7 Sun 1 Mon 1 Tue 1 Wed 1 Thur 1 Fri 1 Sat 1

CLIENT INFORMATION

NAME		BIRTHDATE	SEX
ADDRESS	AIKEN, SC 29803		
TELEPHONE NO.	IPC CLIENT NO.	SOCIAL SEC NO.	MEDICAID NO.	ELIGIBILITY TYPE

RESPONSIBLE PARTY

NAME		
ADDRESS		
RELATIONSHIP	HOME TELEPHONE	WORK TELEPHONE

Physician: _____
Directions to client's home:

Case Manager's Signature: _____ Date: _____

Sent: _____ Date: _____ Initials: _____ ☐ PROVIDER ☐ BILLING CLERK ☐ FILE

SCDHHS FORM 175-B JUL 94

Medicaid Insurance Verification Services
For
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH INSURANCE INFORMATION REFERRAL FORM

This form is designed to give the Medicaid program information that can be used to verify or reverify private health insurance coverage for Medicaid beneficiaries.

Beneficiary Name: _____ Date Referral Completed _____

Medicaid ID#: _____ SSN: _____

Insurance Company Name:_____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Employer's Name: _____

Employer's Address: _____

REASON FOR REFERRAL: (PLEASE SUPPLY AS MUCH INFORMATION AS POSSIBLE)

_____ 1. The beneficiary's Medicaid Eligibility File does not list the policy above.

_____ 2. Insurance documentation gives information that should be used to update Medicaid's files, such as the following:

_____ a. beneficiary has never been covered by the policy

_____ b. beneficiary's coverage ended (date) _____

_____ c. policy lapsed (date) _____

_____ d. carrier has changed; new carrier is _____

_____ e. other _____

PLEASE ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Fax this information to Medicaid Insurance Verification Services at 803 252 0870 **OR**
Please send this form to the following address: Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29211-9804

Provider or Department Name: _____ Provider ID# _____

Contact Person: _____ Phone #: _____

March 2004

STATE OF SOUTH CAROLINA HEALTH AND HUMAN SERVICES	MEDICAID PROVIDER INQUIRY
MAIL TO: ATTENTION _____ UNIT SC DEPT OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE PROVIDER NUMBER, SIX DIGITS – INCLUDE GROUP NBR, IF ANY TELEPHONE
PROVIDER NAME AND ADDRESS	TYPE OF PROVIDER I.E. DENTIST – GP, ETC. DATE CLAIM FILED:

---------- FOLD HERE ----------

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE

HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) ☐ YES ☐ NO	IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ NO

CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17 DIGIT CLAIM REFERENCE NUMBER

STATEMENT OF PROBLEM OR QUESTION	SIGNATURE OF PROVIDER

RESPONSE	AGENCY REPRESENTATIVE	DATE

SCDHHS FORM 140 (NOV. 87) Replaces Form 1735 (Feb. 81) which obselete.

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

PART I *(FOR ALL ITEMS EXCEPT PHARMACY SERVICES CLAIM FORM)*

WHEN COMPLETED PLEASE FORWARD TO:
SC Department of Health and Human Services
Supply
Post Office Box 8206
- or- Columbia, South Carolina 29202-8206
FAX TO: (803) 253-4027

MEDICAID NO:
TYPE OF PROVIDER:
TELEPHONE: - -
CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY *(PLEASE PRINT OR TYPE)*

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

DHHS FORM 142 (5/97)

PART II *(TO BE COMPLETED WHEN ORDERING PHARMACY SERVICES CLAIM FORMS)*

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR STATEMENT OF PHARMACY SERVICES

DHHS FORM 3211 (11/96)

WHEN COMPLETED PLEASE FORWARD OR FAX:
- **REQUEST FOR PREPRINTED FORMS TO YOUR PROVIDER REPRESENTATIVE; OR**
- **REQUEST FOR BLANK FORMS 3211 TO SUPPLY**

MEDICAID NO:
TELEPHONE: - -
CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY *(PLEASE PRINT OR TYPE)*

QUANTITY REQUESTED

PREPRINTED WITH NAME, ADDRESS AND PROVIDER NUMBER [ ] YES [ ] NO

South Carolina
Department of Health and Human Services
Authorization Agreement For Electronic Funds Transfer

Provider Name: _____

Medicaid Provider Type: _____ **Medicaid Provider Number:** _____
Provider EIN Number: _____
Address: _____

City: _____ **State:** _____ **Zip:** _____

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 and that this account is used solely for business purposes. I (we) further agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Please contact your bank to obtain the correct electronic deposit information:

Financial Institution: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Transit/ABA Number: __/__/__/__/__/__/__/__/__/

Account No.: __/__/__/__/__/__/__/__/__/__/__/__/__/__/__/

Type of Account: ___ **Checking** ___ **Savings**

Signed: _____ *(Signature)*

_____ *(Print)*

Title: _____

Date: _____

Contact Name: _____ **Phone:** _____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

RETURN TO:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROVIDER ENROLLMENT
P.O. BOX 8809
COLUMBIA, S.C. 29202-8809
FAX: (803) 699-8637

Revised 11/04

REPORT NH4545R1 SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 1
DATE 12/16/2002 COMMUNITY RESIDENTIAL CARE
FOR MONTH OF FEBRUARY

(1) CRCF NO. RC0999 HAPPY HOME (2)
111 VALLEY ST
LEXINGTON SC 29687

(3) LINE	(4) COUNTY	(5) RECIPIENT NAME	(6) RECIPIENT ID NO	(7) MONTHLY INCOME	(8) DATE OF SERVICE MO/YR	(9) CRCF DAYS	(10) IPC DAYS //	ENTER CHANGES (11) CHANGED CRCF DAYS	(12) CHANGED IPC DAYS	(14) DELETE FROM NEXT MONTH'S TA
01	32	MARY SMITH	1234567801		02/03	28				
02	32	SAM PERKINS	9876543201		02/03		28			
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										
16										
17										

1) IF THE ABOVE INFORMATION IS CORRECT AND THERE HAVE [illegible] ISCHARGES, SIGN AND DATE AS INDICATED BELOW.
2) IF THERE HAS BEEN A NEW OSS APPROVED ADMISSION TO [illegible] THE MONTH OF DECEMBER , ENTER A NEW LINE FOR THAT RESIDENT WITH THE NAME, ID NUMBER, DATE OF ADMISSION AND NUMBER OF DAYS IN YOUR FACILITY.
3) IF THE FACILITY HAS RECEIVED AUTHORIZATION FROM SCDHHS TO PROVIDE INTEGRATED PERSONAL CARE (IPC) SERVICES TO ANY OSS RESIDENT, REDUCE THE NUMBER OF CRCF DAYS BY THE NUMBER OF DAYS THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES AND INSERT THE NUMBER OF DAYS THE RESIDENT RECEIVED AUTHORIZED IPC SERVICES IN THE IPC DAYS COLUMN.
4) IF THERE HAS BEEN A DISCHARGE/DEATH FROM YOUR FACILITY DURING THE MONTH OF DECEMBER, INDICATE THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY IN THE COLUMN TITLED "CHANGED CRCF DAYS". IF THE RESIDENT WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES, ENTER THE NUMBER OF DAYS, NOT COUNTING THE DATE OF DISCHARGE/DEATH THAT THE RESIDENT WAS IN YOUR FACILITY AND WAS AUTHORIZED FOR AND RECEIVED IPC SERVICES IN THE "CHANGED IPC DAYS" COLUMN.
5) IF ANY OF THE RESIDENTS LISTED WILL NOT BE IN YOUR FACILITY NEXT MONTH, ENTER AN 'X' IN THE COLUMN TITLED 'DELETE FROM NEXT MONTH'S TAD'.

I CERTIFY THAT THE INFORMATION SHOWN ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO GENERATE PAYMENTS OF STATE FUNDS, AND I UNDERSTAND THAT SUBMITTING FALSE OR MISLEADING INFORMATION IS AGAINST THE LAW AND COULD RESULT IN CRIMINAL PROSECUTION.

SIGNATURE TITLE DATE

NHM4530R03 (1)
RUN DATE 12/09/2002

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMMUNITY RESIDENTIAL CARE
OPTIONAL STATE SUPPLEMENTATION REMITTANCE ADVICE

CRCF NO. RC0XXX (2)

CHECK DATE:12/13/02 (3)
CHECK NUMBER:2999994 (4)
CHECK AMOUNT:$000.00 (5)

BANK NAME: (6)
BANK NUMBER: (7)
ACCOUNT NUMBER: (8)

LINE	(9) RECIPIENT NAME		(10) RECIPIENT ID NO	(11) DATE OF SERVICE	(12) CRCF DAYS	(13) INCOME	(14) OSS/IPC PAYMENT	(15) STATUS CODE	(16) EDIT CODE	(17) CLAIM CONTROL NUMBER
01	GERALDINE	ALSTON	2889990001	11/01/02	10	$000.00	$0.00	8 P	, ,	0233199999130000G
01							$000.00			
02										
02										
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