

FORMS

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DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	05/2007
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	Sample Edit Correction Form	
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	Death Reporting Worksheet	01/2010
	Residential Treatment Facility Admission/Discharge Notification for HCK Beneficiaries	01/2010



**STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)

MEDICAID RECIPIENT ID NUMBER: (if applicable)

ADDRESS OF SUSPECT:

LOCATION OF INCIDENT:

DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)

SIGNATURE OF PERSON REPORTING:

DATE OF REPORT

ADDRESS OF PERSON REPORTING:

TELEPHONE NUMBER OF PERSON REPORTING:

SIGNATURE: (SCDHHS Representative Receiving Report)



**STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE:
	NPI or MEDICAID PROVIDER ID:
	TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, 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)		IS MEDICARE COVERAGE INVOLVED?	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> 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

**South Carolina Department of Health and Human Services
Form for Medicaid Refunds**

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed.

Attach appropriate document(s) as listed in item 8.

1. Provider Name: _____

2. Medicaid Legacy Provider #
(Six Characters)

OR

3. NPI#

& Taxonomy

4. Person to Contact: _____

5. Telephone Number: _____

6. Reason for Refund: [check appropriate box]

- Other Insurance Paid (please complete a – f below and attach insurance EOMB)
 - a Type of Insurance: () Accident/Auto Liability () Health/Hospitalization
 - b Insurance Company Name _____
 - c Policy #: _____
 - d Policyholder: _____
 - e Group Name/Group: _____
 - f Amount Insurance Paid: _____

- Medicare
 - () Full payment made by Medicare
 - () Deductible not due
 - () Adjustment made by Medicare

Requested by DHHS (please attach a copy of the request)

Other, describe in detail reason for refund:

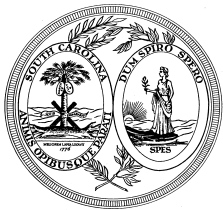
7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

- Medicaid Remittance Advice (required)
- Explanation of Benefits (EOMB) from Insurance Company (if applicable)
- Explanation of Benefits (EOMB) from Medicare (if applicable)
- Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM**

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110
Columbia, SC 29211-9804

**III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)**

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax: 803-255-8225 **or** **Mail:** Post Office Box 8206, Attention TPL
Columbia, SC 29202-8206



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION**

PROVIDER _____ **DOS** _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

**I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE
FROM THE PRIMARY INSURER.**

(SIGNATURE AND DATE)

**ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR
MEDICAID CLAIMS PROCESSING POST OFFICE BOX.**

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

PROVIDER INFORMATION

Provider Name _____
Medicaid Provider Number _____
Provider NPI Number _____
Provider Address _____
City _____ State _____ Zip _____

BANKING INFORMATION (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

Financial Institution Name _____
Financial Institution Address _____
City _____ State _____ Zip _____
Routing Number (nine digit) _____
Account Number _____
Type of Account (check one) Checking Savings

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ (Signature)

_____ (Print)

Title _____ Date _____

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

RETURN COMPLETED FORM TO:

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

Sample UB-04

1		2										3a PAT. CNTL #		4 TYPE OF BILL																									
												b. MED. REC. #																											
												5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH																							
8 PATIENT NAME		9 PATIENT ADDRESS																																					
b		c										d		e																									
10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACCT STATE		30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 CODE		36 OCCURRENCE SPAN FROM		THROUGH		37 CODE		38 OCCURRENCE SPAN FROM		THROUGH																					
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38		39 CODE		39 VALUE CODES AMOUNT		40 CODE		40 VALUE CODES AMOUNT		41 CODE		41 VALUE CODES AMOUNT		42		43		44		45		46		47		48		49		50		51		52					
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42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		51		52		53		54		55		56		57		58		59					
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C																																							
58 INSURED'S NAME		59 P.REL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.		63		64		65		66		67		68		69		70		71		72		73		74							
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63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66		67		68		69		70		71		72		73		74		75		76		77		78		79							
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69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73		74		75		76 ATTENDING NPI		QUAL		77 OPERATING NPI		QUAL		78 OTHER NPI		QUAL		79 OTHER NPI		QUAL		80									
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74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 OTHER PROCEDURE CODE		77 OTHER PROCEDURE CODE		78 OTHER PROCEDURE CODE		79 OTHER PROCEDURE CODE		80 OTHER PROCEDURE CODE		81		82		83		84		85		86		87		88		89									
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RUN DATE 10/09/2007 D00108760
REPORT NUMBER CLM3500
ANALYST ID
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES
EDIT CORRECTION FORM
INPATIENT/OUTPATIENT - 01
DOC IND

CLAIM CONTROL #D999999999999999Z
PAGE 18290 ECF 99999 PAGE 1 OF 1
EMC Y
ORIGINAL CCN: 9999999999999999Z
ADJ CCN: 123456789123456U
INSURANCE EDITS
CLAIM EDITS

RECIP NAME JANE DOE DOB 01/01/1991 SEX F

NPI: 1234567890 TAXONOMY: 323P00000M PRV ZIP: 29526
51) PRTF029 3) W00895C1251493 4) 117 6) 10/03/07 10/07/04 7) 004 004 60) MEDICAID RCP ID 0123456789

17) 10/17/06 19) 1 20) 7 22) 20 23) 24) C5 25) 26) 27) 28) 29) 30) CLAIM EDITS 000-593

32A) 42 09/07/07 33A) / / 34A) / / 35A) / / 36A) / / - / /

32B) / / 33B) / / 34B) / / 35B) / / 36B) / / - / /

37) 012600031230500Z

39A)
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41A)
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!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
! !
! EDIT PAYMENT DATE !
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90

MEDICAID CARRIER ID 619

1ST OTHER PAYER 50)
2ND OTHER PAYER 50)

54) 60)
54) 60)

54P) 63) PP40122 DRG 99B REIMBURSEMENT G

(67) (68) (69) (70) (71) (72) (73) (74) (75) (76)
296.54 296.54

80) . / / 81A) . / / 81B) . / / 82) 1194826081
81C) . / / 81D) . / / 81E) . / / 83A) 1194826081
83B)

INSURANCE POLICY INFORMATION

RES LINE (42) (44) (45) (46) (47) (48)
001 124 0004 1126.60 0.00
TOTAL CHARGES 001 1126.60 0.00

UNISON HEALTH PLAN OF SC
(800) 366-7304

RESOLUTION DECISION ___ RETURN TO: MEDICAID CLAIMS RECEIPT, P.O. BOX 1458, COLUMBIA, SC 29202-1458

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

Sample Remittance Advice

AB0008 ABC PROVIDER

PO BOX 000000

ANYWHERE

SC000000000

.121212121234.

Y

PROVIDER ID.

PROFESSIONAL SERVICES

PAYMENT DATE

PAGE

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+-----+ DEPT OF HEALTH AND HUMAN SERVICES +-----+
| AB00080000 | REMITTANCE ADVICE | 03/26/2008 | 1 |
+-----+ SOUTH CAROLINA MEDICAID PROGRAM +-----+
  
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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
2212345	0406001089000400A 01		021508	T2028	50.00	50.00	P	1112233333	M CLARK			0.00	0.00
					50.00	50.00	P						
							P						
1122322	0406001089000400U 01		012108	T2020	110.00	110.00	P	1112233333	M SMITH			0.00	0.00
					50.00	50.00	P						
					60.00	60.00	P						
1124533	0407701389002500A 01		012108	E2020	106.00	106.00	P	1112233333	M CLARK			0.00	0.00
					60.00	60.00	P						
					46.00	46.00	P						
TOTALS			3		266.00	266.00					0.00	0.00	

\$266.00

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+-----+ +-----+ STATUS CODES: PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE CERT. PG TOT MEDICAID PG TOT +-----+
ERROR CODES LISTED ON THIS +-----+ +-----+ P = PAYMENT MADE | ABC PROVIDER
FORM REFER TO: "MEDICAID | $0.00 | $266.00 | R = REJECTED |
PROVIDER MANUAL". +-----+ +-----+ S = IN PROCESS | PO BOX 000000
CERTIFIED AMT MEDICAID TOTAL E = ENCOUNTER | ANYWHERE XO 00000-0000 |
IF YOU STILL HAVE QUESTIONS+-----+ +-----+ +-----+ +-----+ |
PHONE THE D.H.H.S. NUMBER | $0.00 | $0.00 | $266.00 | 9999999 |
SPECIFIED FOR INQUIRY OF +-----+ +-----+ +-----+ +-----+ |
CLAIMS IN THAT MANUAL. FEDERAL RELIEF MAXIMUS AMT CHECK TOTAL CHECK NUMBER
  
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REQUEST FOR EMERGENCY ADMISSION CONCURRENCE (REAC)

Psychiatric Hospital: _____ **NPI or Medicaid Provider ID:** _____

Client Name: _____ **Date of Birth:** _____

Client Medicaid #: _____ **SSN:** _____

Referral Source: _____ **Date of Admission:** _____

The above named client was admitted as an emergency based on the following conditions:

Physician/ Representative Signature & Title

Date

_____ Date Received by _____ State Agency (SA)/_____ Community Mental Health Center (MHC)

_____ Based only on the above information, the above named client DOES appear to meet Medicaid's administrative definition of an emergency admission.

_____ Based only on the above information, the above named client DOES NOT appear to meet Medicaid's administrative definition of an emergency admission. However, the client DOES appear to require psychiatric hospital services and can be admitted as an urgent admission. (*SA/MHC must complete the CON)

_____ Based only on the above information, the above named client DOES NOT appear to meet Medicaid's administrative definition of an emergency admission NOR does the client appear to need any psychiatric hospital services at this time

SA/MHC Representative and Title: _____ **Date:** _____

SA/MHC Physician Signature: _____ **Date:** _____

Note: The CON is to be completed by the SA responsible for the provision of services to the client. If the client is not involved with a referring SA, the MHC completes the CON.

**PSYCHIATRIC HOSPITALS
FOR INDIVIDUALS UNDER AGE 21
SOUTH CAROLINA MEDICAID
NOTICE OF NON-COVERAGE FOR
INPATIENT PSYCHIATRIC HOSPITAL CARE**

DATE _____ NPI OR MEDICAID PROVIDER ID _____

NAME OF CLIENT _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

ATTENDING PHYSICIANS NAME _____ ATTENDING PHYSICIAN'S PHONE # _____

Dear: _____ :

The purpose of this letter is to inform you that _____ Hospital:

() Has determined that your psychiatric hospital admission is not covered under the Medicaid program because

() Has determined that further inpatient psychiatric hospital treatment is no longer medically necessary. Furthermore, (Check One):

- Your attending physician **agrees** that continued hospitalization is no longer needed.
- Your attending physician **disagrees** that continued hospitalization is no longer needed, but Qualis concurs with our facility.

If you elect to be admitted and/or remain in the hospital, you are financially liable for all costs of the care you receive except for any convenience services or items normally not covered by the Medicaid program, beginning on _____. This determination does not mean additional psychiatric services are not needed. Medicaid reimbursement may be available for these additional services; however, you do not need inpatient hospital placement to receive these services. You should discuss, with your attending physician and/or a representative from the agency that made your placement, other arrangements for any further health care you may require.

This notice is not an official Medicaid determination. Qualis is the Quality Improvement Organization authorized by the Medicaid program to review inpatient psychiatric hospital services provided to Medicaid clients in the state of South Carolina.

If you disagree with our decision, you may request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through the facility or directly to Qualis at the address listed below:

Qualis Health
440 Knox Abbott Drive Suite 220
Cayce, SC 29033
(803)-739-2755

Qualis will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the facility).

If you do not request a review by noon of the first working day after receipt of this notice you may still request that Qualis review at any point during your stay or within 30 days after you receive this notice, whichever is longer.

Qualis will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

If Qualis disagrees with the facility, you will be refunded any amount collected by the facility except for any convenience services or items normally not covered by Medicaid.

If Qualis agrees with the facility, you are financially responsible for all services beginning on _____ through your discharge date unless you request an immediate review. If you request an immediate review (i.e, you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you received Qualis's notification.

Sincerely,

Hospital Representative

cc: Qualis Health
Beneficiary
Attending Physician
Legal Guardian
Authorized Referral Entity
SCDHHS Department of Behavioral Health Services, Attn: Non-Coverage

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

*This is to acknowledge that I received this notice of non-coverage from _____ on _____.
I understand that my signature below does not indicate that I agree with this notice, only that I have received a copy of this notice.*

Signature of beneficiary or legally responsible party

Date

Client or legally responsible party refused to sign this notice, but was told that this admission is not covered by Medicaid.

Witness

Date

Witness

Date

Sample Attestation Letter

An individual who has the legal authority to obligate the facility must sign this attestation.

[Name of the Psychiatric Residential Treatment Facility]
[Address]
[City, State, Zip Code]
[Telephone Number]
[Fax Number (if applicable)]

Provider Number

Dear <State Medicaid Director>:

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the <NAME of the FACILITY> hereby complies with all of the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA), SCDHHS or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 431.610, have the right to validate that <Name of the Facility> is in compliance with the requirements set forth in the Psych Under 21 rules, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the SCDHHS immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify SCDHHS if it is my belief that <Name of the Facility> is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature
Printed Name
Title
Date

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES**

Beneficiary Name: _____

CALOCUS SCORE SHEET

Record the applicable rating, criteria and comments for each dimension. Total your score and determine the recommended level of care.

LEVEL OF CARE	SCORE		COMMENTS (Beneficiary information for which rating is based)
	Rating	Criteria	
I. Risk of Harm			
II. Functional Status**			
III. Co-Morbidity**			
IV-A. Recovery Environment Level of Stress			
IV-B. Recovery Environment Level of Support			
V. Resiliency and Treatment History			
VI-A. Acceptance and Engagement Child or Adolescent			
VI-B. Acceptance and Engagement Parent or Primary Caretaker			
COMPOSITE SCORE _____			LEVEL OF CARE _____

Bold – Indicates independent criteria requires automatic admission to a higher level of care regardless of combined score. A score of 4 results in the placement at Level 5 and a score of 5 results in the placement at Level 6.

****** – For a score of 4, independent criteria may be waived if sum of IV-A and IV-B scores equal 2.

Rater Name/Title: _____ **Date** _____

ADDITIONAL INFORMATION: _____

When the CALOCUS score indicates a Level 4, 5 or 6, PRTF placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered.

DEATH REPORTING WORKSHEET - PRTFS	
CONTACT INFORMATION	
RO contact's name	
Date of RO contact	
RO contact's phone number	
Facility contact	
Facility contact's phone number	
PROVIDER INFORMATION	
PRTF Name	
Medicaid Number	
Address	
Zip Code	
PATIENT INFORMATION	
Name	
Date of Birth/Age	
Medicaid Number	
Admitting Diagnoses	
Date of Admission	
Date/time of Death	
Cause of Death	
Did the facility conduct a root cause analysis	
NOTE: PRTFs may provide the following information over the telephone, or to the SA during its investigation	
Length of Time in restraints/Seclusion:	
Circumstances Surrounding the Death:	
Results of any facility investigation:	
RESTRAINT/SECLUSION INFO	
Type of Restraint	Personal
	Mechanical
	Seclusion
	Drug used as Restraint
Restraint Method	
Reason(s) for Restraint/Seclusion use:	
Less restrictive methods of behavior management considered:	

DEATH REPORTING WORKSHEET - PRTFS

Restraint/Seclusion order date/time:

Quote actual restraint/seclusion order(s):

Restraint/seclusion ordered by: Physician _____ Other Licensed Practitioner _____ and Trained in use of emergency safety interventions? Yes _____ No _____

Was the resident's treatment team physician contacted (unless same as ordering physician)
Yes _____ No _____

Was the resident evaluated immediately after restraint removed/removed from seclusion?
Yes _____ No _____

Monitoring method(s), frequency, last date/time monitored:

Last date/time of assessment:

Additional

Information/Comments:

Action Information

Facility notifications

Other agencies the provider notified (SMA, SA, etc.):

Agency/date/time: _____

Agency/date/time: _____

Agency/date/time: _____

Agency/date/time: _____

SA Action(s)

Date of receipt of restraint/seclusion death report from PRTF: _____

Date of Survey: _____

RO Actions(s)

Date of receipt of restraint/seclusion death report from PRTF: _____

Date sent as complaint to SA (if applicable) _____

Date/Method/Person notifying CO: _____

CO Action(s)

Date of receipt of initial restraint/seclusion death report from RO: _____

Date of receipt of restraint/seclusion death report worksheet: _____

Person recording the information: _____



**RESIDENTIAL TREATMENT FACILITY
ADMISSION/DISCHARGE NOTIFICATION FOR HCK BENEFICIARIES**

Payment Category: _____
Provider must verify eligibility.
If Payment Category is not 99, do not complete this form.

TYPE OF NOTIFICATION
(check one)
 ADMISSION
 DISCHARGE

*If a child has HCK coverage and is being admitted to a residential treatment facility (Psychiatric Residential Treatment Facility or substance abuse), the facility or referring state agency must notify SCDHHS Eligibility, using this form, at the time of Admission and at the time of discharge.

HCK Beneficiary Information:
Name _____
DOB _____
HCK ID Number _____ Social Security Number _____

Facility Information:
Facility Name _____
Address _____
Phone: _____ Contact Person: _____

Date of Residential Admission: _____

Date of Residential Discharge: _____

COMMENTS: _____

Printed Name and Title of Authorized Staff _____

Authorized Staff Signature _____

Date _____

Mail or fax completed forms to:
SCDHHS – Eligibility-Constituent Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: 803-255-8350