FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
	Sample Remittance Advice (two pages)	
181	Authorization Form 181 with Instructions (two pages)	05/2018
235	Request for Approval of Non-Covered Medical Expenses	07/2008
236	Log of Incurred Medical Expenses (two pages)	07/2008
185S	Complex Care Supplemental Assessment Form (two pages)	09/2017
247	Social History for MI Level II PASRR Screening (two pages)	04/2017
248	Social History for ID Level II PASRR Screening (two pages)	04/2017
249	PASRR Referral Packet Cover Letter	05/2007
250	Psychiatric Evaluation Level II (three pages)	01/1992
185	Level of Care Certification Letter (two pages)	11/2003
121	Consent Form	06/2003
234	PASRR Level I Screening Tool (six pages)	02/2026
	PASRR Level I Screening Tool Instructions (two pages)	02/2026
210	Resident Case Mix Classification Change (two pages)	04/2017
1231 ME	Request for Assessment of Level of Care	06/2003
	PFAs Core Curriculum — Attachment B (two pages)	

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:		
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)	
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:	
	DATE OF INCIDENT:	
COMPLAINT:		
NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT
ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:	
	SIGNATURE: (SCDHHS Representative Receiving Report)	

SCDHHS Form 126 (revised 06/07)

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

DHHS Form 205 (01/08)

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

Provider or Department Name: ________________________________ Provider ID or NPI: ____________________

Contact Person: ____________________ Phone #: ______________________________ Date: ______________

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

Beneficiary Name: ___________________________________ Date Referral Completed: _______________________

Medicaid ID#: ______________________________________ Policy Number: ______________________________

Insurance Company Name: ____________________________ Group Number: ______________________________

Insured's Name: _____________________________________ Insured SSN: ________________________________

Employer's Name/Address: ____

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

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

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

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

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

- new policy number is __________________________________

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

(name) ____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

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

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: ____

2. Medicaid Legacy Provider # ___________ (Six Characters)

   NPI# ________________________ Taxonomy ______________________

3. Person to Contact: _______________ Telephone Number: _______________

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:
   ____
   ____
   ____
   ____
   ____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: __________________________

   City: ____________________________

   State: ___________________________

   Zip Code: ________________________

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

______________________________ ______________________
Authorizing Signature **Date**

SCDHHS (Revised 09/01/17)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086
or
Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): ______________________________

Date of Birth: ____________ Medicaid Beneficiary ID: ____________

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): ____________

NPI: ____________ Medicaid Provider ID: ____________ Facility/Group/Provider Name: ____________

Return Mailing Address: ______________________________
Street or Post Office Box *State* *ZIP*

Contact: ____________ Email: ____________ Telephone #: ____________ Fax #: ____________

Section 3: Claim Information ***(Only one CCN allowed per request.)***

Communication ID: ____________ CCN: ____________ Date(s) of Service: ____________

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals
  Specify: ______________________________
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: ______________________________

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: ______________________________

Signature: ______________________________ Date: __________

Sample Remittance Advice (page 1)

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

PROVIDER ID. 000000000		REMITTANCE ADVICE	PAYMENT DATE	PAGE
0123NF	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM	NURSING CARE SERVICES	05/04/2007	1

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

	SCHAP	MEDICAID
PG TOT	$0.00	$3975.25
TOTAL		$3975.25

CHECK TOTAL:

CHECK NUMBER:

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

PROVIDER NAME AND ADDRESS

ACME NURSING FACILITIES
P O BOX 000000

ANYWHERE SC 00000-0000

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

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

Sample Remittance Advice (page 2)

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

PROVIDER ID.			PAYMENT DATE	PAGE
0123NF	000000000 DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM	CLAIM ADJUSTMENTS	05/04/2007	2

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

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

	ADJUSTMENTS	
	-979.88	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
	2995.37	12424579

PROVIDER NAME AND ADDRESS

ACME NURSING FACILITIES

P O BOX 000000
ANYWHERE SC 00000-0000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Admission, Authorization & Change of Status for Long Term Care

things to know

General Information

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

Detailed Instructions

A. Section I – Identification of Provider and Patient:

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 7. This suffix (either alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card). The Provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider number.**

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

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in level of care changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates. Level of care must be reported on all DHHS Form 181s.

For Authorization, send Form 181 to: SCDHHS Central Mail
PO Box 100101
Columbia, SC 29202

Fax: (888) 820-1204

If the recipient has a non-covered medical expense, complete Forms 235 and 236. Send completed forms, if applicable, to: SCDHHS Division of Policy and Planning
PO Box 8206
Columbia, SC 29202-8206.

For Complex Care Terminations fax to SCDHHS Nursing Facility Service: (803) 255-8209.

C. Section III – Authorization and Change of Status:

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

Co-Insurance

In the case of filing for Medicare Coinsurance, a SNF Authorizing DHHS FORM 181 must be completed for each Medicare spell of illness. Coinsurance periods are billed using a copy of the initial signed authorization. Coinsurance dates must be supported by EOMBs; must not cross a calendar month; and the service dates must be consecutive.

The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly billing. **NOTE:** Effective with dates of service 12/01/01, DHHS no longer reimburses nursing facilities or ICFs/IID for Part A SNF coinsurance. Swing Bed Hospitals are paid coinsurance. **Coinsurance claims should never be sent with the monthly billing.**

Distribution, Preparation and Routing of Form

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

A. Copy — Submitted by Provider for claims processing at MCCS.
Copy — Retained and kept on file by SCDHHS Medicaid Eligibility.
Original — Retained and kept on file by the Provider of services.

B. The Provider of services must attach a copy of this form to the current month's billing for each change in the status of a patient. Staple all 181 forms together for each patient.

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

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

Healthy Connections MEDICAID

Notice of Admission, Authorization, and Change of Status for Long Term Care

Must Be Typed or Completed in Blue or Black Ink

Provider Fax Number:

Hospice enrolled on or before admission: ☐ (Check if Yes)

RESET FORM

Income Trust? ☐

Section I. Identification of Provider and Patient (Completed by Provider/Facility)

1. Beneficiary Name (First, Middle, Last)
2. Birth Date (MO-DY-YY)
3. Medicaid No. (10 digits)
4. Facility Name
5. Facility Street Address

City | State | ZIP

6. County of Residence
7. Social Security No. - HIB Suffix
8. Provider Medicaid ID
9. Date of Request
10. Authorized Representative's Name
11. Authorized Representative's Phone No.
12. Authorized Representative's Street Address

City | State | ZIP

This Box for DDSN Therapy Wages Only: ☐ Start ☐ Significant Change $ ☐ Stop Effective Date

Section II. Type of Coverage and Statistical Data

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

(A) ☐ SKILLED CARE (LOC1) ☐ INTERMEDIATE CARE (LOC2) ☐ SNF COINSURANCE (MEDICARE LOC6)

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

(C) ADMITTANCE DATE FOR: - DATE:

(D) TRANSFERRED - - (MO-DY-YY) (NAME OF OTHER FACILITY)

(E) READMITTED FROM HOSPITAL STAY: (MO-DY-YY)

(F) NUMBER OF DAYS ABSENT FROM FACILITY: COVERED DAYS:

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

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

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

(J) ACTION: - DATES OF SERVICE: THRU

ACTION: - DATES OF SERVICE: THRU

COMMENTS:

Section III. Authorization and Change of Status (Completed by DHHS EEMS Only)

14. Recommendation of SCDHHS Medicaid Eligibility Worker

(A) Authorization to Begin Date: (MO-DY-YY) (B) Applicant not qualified for long term care because: Financial Criteria Not Met ☐ Non-Financial Criteria Not Met ☐

(C) Beneficiary's Initial Applicable Recurring Income (Total Income Less Personal Allowance) $

(D) Change in Beneficiary Income (Total Income Less Personal Allowance) $ (MO-YYYY)

(E) Financially eligible, but waiting to be placed in a nursing home ☐

(F) Personal Needs Allowance $

(G) Other:

Section IV– Signature

Name of Eligibility Worker (Print)	Eligibility Worker Signature	Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Approval of Non-Covered Medical Expenses

FROM: ____

____

____

____

(Name & Address of Facility)

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

Regarding: ____________________________ ____________________________

(Beneficiary's Name) (Medicaid ID#)

Part I

(To be completed by facility)

Description of item/service received:

____

____

____

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

____

____

____

Cost of item/service:

____

Part II

(To be completed by SCDHHS)

Item/Service approved for deduction:

☐ Yes ☐ No (check one)

If Yes, $ ________________ may be deducted.

Signature: ______________________________ Date: ______________________________

Division of Medicaid Policy and Planning

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Log of Incurred Medical Expenses

For the Month of _______________

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

Beneficiary's Name: ____

Medicaid ID Number: ____

Month: ____

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

Monthly Recurring Income (SCDHHS Form 181) ______________________

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

Amount carried over to next month** ______________________

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

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

The following deduction amounts outlined replace amounts determined in 1989:

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

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

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

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

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

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

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

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

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COMPLEX CARE PROGRAM SUPPEMENTAL ASSESSMENT FORM

Contact Email: Complexcare@scdhhs.gov or Fax: (803) 255-8209.
Check status of applications by 5th business day.

Applicant_______________________________ Medicaid #_______________________________

Name & Title of Staff Completing Form_______________________ Fax/Email _______________________

2nd Staff Contact Name & Title_______________________ Fax/Email_______________________

Facility Completing Form_______________________ Date Completed:_______________________

Initial Referral ☐	**Recertification** ☐ **Requested Recertification dates: To**____________**From** ____________

Submit initial referral when applicant is in hospital/acute inpatient for 10 consecutive days. Inpatient Admission date: ________

Check Applicants Insurance: ☐ **Medicaid** ☐ **Medicare A** **Medicare #** _______________________

Category/Treatment	Additional Information	Documents to send with referral
Circle/fill in categories that apply to the applicant. Send admit note/H&P, Insurance carrier(s), and supportive documents.		
☐ **Stage 4 /pressure ulcer only**	**(Attach staging note of stage 4 pressure wound only)**	
☐**Tracheostomy**	☐ **Tracheostomy tube/cannula** ☐**Tracheal cleaning**	**(Attach tracheostomy care/suction orders)**
☐**Oral Suctioning** **By respiratory care unit or nursing facility staff**	**Purpose:** **Frequency** ____________	**(Attach care/suction note if applicable)**
☐**Total Parenteral Nutrition** ☐**Partial Parenteral Nutrition** Given by IV- Intravenous access only, No Antibiotics	☐**Expected duration of 2 weeks or more** **Name of TPN/PPN nutrition therapy:** ________	**(Attach Medication list/orders for TPN/PPN therapy)**
☐**Disruptive Behaviors 60% of the time requiring 1:1 assistance or restraints**	**List conditions /Behaviors:**	**(Attach additional information)** ☐ PASRR Level II-completed ☐Psychiatry Evaluation recommendation
☐ **Diagnosis of Morbid Obesity** (BMI 40 or higher and at least 100 pounds over ideal weight must include other d/x and need assistance with 1 ADL)	☐**Bed** ☐**Lift Type** ☐**Wheelchair**	**(Attach charted measurements)** Height__________**ft.** ________**in** Weight__________**lb.** [or]_**kg** Comorbidity: ______________
☐ **Goal directed therapies** Received therapist totaling 5 days per week for 2 of 3 disciplines.	☐**PT** ☐**OT** ☐**ST** **Frequency:**	**(Attach PT/OT/ST treatment plan/ goals/progress notes)**
☐ **Ventilator Dependent** (life sustaining for 6 or more hours a day)	**Name & List settings**	**(Attach ventilator orders/settings)**
☐ **Dialysis**	**Frequency**	**(Attach Dialysis schedule)**
☐ **HIV** (CD4 level equal to or less than 500)	**Taking 2 or more medications for HIV treatment**	**(Attach medication list for HIV treatment)**

Applicant Name ____

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

1. **INDEPENDENT** - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
2. **SUPERVISION** - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

LIMITED ASSISTANCE - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days

3. **EXTENSIVE ASSISTANCE** - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time:
   --Weight-bearing support
   --Full caregiver performance during part (but not all) of last 7 days
4. **TOTAL DEPENDENCE** - Full caregiver performance of activity during entire 7 days

DEFINITIONS

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

	Code Here
TRANSFER	
LOCOMOTION	
DRESSING	
EATING	
TOILET USE	

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

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

	Code Here
BATHING	

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

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

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

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

☐ Approved Effective Date From_______________To______________________

☐ Denied Reason(s) ____

SCDHHS Representative________________________________Date: ____________________________

SCDHHS Form 185S
August 2017

SOCIAL HISTORY FOR MI LEVEL II PASRR SCREENING

Client Name: ______________________________ CLTC #: ______________

1. Appearance: ______________________________

2. Ability to Communicate: ______________________________

3. Mental Status: ______________________________

4. Observed Behavior: ______________________________

____

5. Current Living Situation: ______________________________

____

6. Significant Family History: ______________________________

____

7. Social/Personal and Support Systems: ______________________________

____

____

8. Maladaptive/Inappropriate Behavior: ______________________________

____

____

9. Past Mental Health History: ______________________________

____

____

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

____

____

11. Present Treatment: ______________________________

____

12. Summary/Comments: ______________________________

____

____

Signature: ______________________________ Date:

DHHS Form 247 (7/92)

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

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

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

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

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

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

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

8) Comment further on behavioral indicators.

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

11) Comment on present mental health treatment.

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

SOCIAL HISTORY FOR ID LEVEL II PASRR SCREENING

Client Name: ______________________ CLTC #: ______________

1. Appearance: ______________________
2. Ability to Communicate: ______________________
3. Mental Status: ______________________
4. Observed Behavior: ______________________
5. Birth and Early Development History: ______________________
6. Social Development: ______________________
7. Social/Personal Significant Family History: ______________________
8. Independent Living Development/Ability: ______________________
9. Maladaptive/Inappropriate Behavior: ______________________
10. Medical History: ______________________
11. Impact of Medical Problems on Individual's Functioning: ______________________
12. Community Social Supports: ______________________
13. Summary/Comments: ______________________

Signature: ______________________ Date:

User's Guide for Social History for ID Level II PASRR Screening

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

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

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

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

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

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

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

9. Comment further on behavioral indicators.

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

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

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

PASRR REFERRAL PACKET COVER LETTER

Date:

To: ______________________________ From:

____

____

RE:

Dear: ____________________________________:

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

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

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

Sincerely,

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

NAME:	SSN:	DATE:

I. PSYCHIATRIC HISTORY

A. Hospitalizations

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

____

B. Outpatient History

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

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

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

____

II. PSYCHIATRIC CONDITION

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

Y = Yes N = No U = Unspecified or Unknown

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

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

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

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

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

NAME:

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

1. Auditory Hallucinations: Commonly thought of as "hearing voices". Y N U

2. Visual Hallucinations: Seeing things and/or people that are not there. Y N U

3. Delusions: A false personal belief based on incorrect inference. Y N U
   a. Persecutory: The feeling that people are out to harm one. Y N U
   b. Grandiose: An exaggerated sense of Importance or power. Y N U

4. Hypochondriacal: A preoccupation with the fear or belief of having a disease. Y N U

5. Obsessive or ritualistic: Recurrent, persistent thoughts/actions that are not experienced as voluntary; perceived as compelling. Y N U

6. Phobias: An irrational fear of a specific object, activity or situation. Y N U

7. Acted on content. Has the patient ever acted in response to or as a result of a delusion or hallucination? Y N U
   Describe the action or behavior:
   ____
   ____

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

1. Expresses ideas of suicide or homicide. Example: Have you ever had thoughts of hurting yourself? Have you thought of how you would do it? Y N U

2. Has made plans for suicide/homicide. Example: Have you ever tried to hurt yourself? What did you do? Y N U

3. Has made suicidal/homicidal gestures or attempts. Example: Have you ever felt so angry you wanted to hurt someone, or attempted to? Y N U

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

1. Cooperative: An ease and confidence; give and take eye contact and animation. Y N U

2. Paranoid: Guarded, suspicious, untrusting attributes; negative intent to questions and actions of others. Y N U

3. Withdrawn: Little/no eye contact, pulling/turning away, asks to be left alone, volunteers little. Y N U

4. Resistive: Withholding of information, answers brief and literal; gives little. Y N U

5. Fearful: Anxious about purpose or intent; Physically holding self or pulls away; worries, frets. Y N U

6. Hostile: Belligerent, angry, refuses to answer or deliberately misleads or misinforms; uncooperative. Y N U

7. Other (Describe):______________________________________
   ____

G. Speech.

1. Pressured: Speech that is difficult to interrupt because of its speed, amount, or accelerated pace. Y N U

2. Blocked: Interrupted speech before a thought or idea has been fully expressed. Y N U

3. Rapid: A nearly continuous flow of speech of an extremely accelerated pace. Y N U

4. Echolalic: Patient repeats the words/phrases of others-not to be confused with efforts to clarify questions. Y N U

5. Slow: Long pauses between words; may appear that patient has to give much thought to each word. Y N U

6. Nonsensical: Speech may consist of words or sounds but they have no clear relationship to a thought or idea. Y N U

7. Normal: Speech consists of words that are organized to communicate coherent thoughts and ideas. Y N U

H. Behavior.

1. Agitated or hyperactive: Very mobile, pacing, fidgety, always busy. Y N U

2. Combative: Strikes others without provocation; unpredictable, aggressive, acting out behavior. Y N U

3. Repetitive purposeless activity: Repeats the same behavior over and over with no clear purpose. Y N U

4. Abnormal, involuntary movements: Parts of the body appear to jerk or twitch. Y N U

5. Rigid body and/or extremities: Patient's body appears rigid; patient does not move voluntarily; wooden. Y N U

6. Slow or lack of body movements: Patient moves voluntarily but extremely slow. Y N U

7. Motor restlessness: Restless feeling from within; will rub arms/legs; moves legs up and down; cannot relax. Y N U

8. Gait abnormality: Writhing, dancing or shuffling motion to gait. Y N U

9. Other Describe):______________________________________
   ____

CLIENT NAME: **SSN:**

III. INDEPENDENT EVALUATION REPORT AND RECOMMENDATION

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

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

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

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

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

DIAGNOSIS:____

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

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

Basis for these conclusions:

Physician Signature: Date:

SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: ____ COUNTY OF RESIDENCE: ____________________________

SOCIAL SECURITY #: ____________________________ MEDICAID #: _______________________________________

LOCATION AT ASSESSMENT:

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

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

- ☐ According to Medicaid criteria, you meet the medical requirements to receive long-term care at the following level:

  ☐ SKILLED ☐ INTERMEDIATE

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

This letter must be presented to the long-term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT ___________________ TO REAPPLY.
Telephone No.

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

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

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

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

FOR LONG-TERM CARE FACILITY USE

- ☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

- ☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: ____ Expiration Date: ________________________________

Nurse Consultant Signature: ______________________________ Date: ____

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

SENT: Date: _____________________________________ Initials: _______________

DHHS FORM 185 (Nov. 2003)

APPEALS

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

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

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

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

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

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

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

SOUTH CAROLINA COMMUNITY LONG TERM CARE

CONSENT FORM

Client Name: ____

Social Security Number: ______________________________________

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

This evaluation includes information provided by:

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

I hereby authorize any social service professionals, organizations, doctors, nurses, or other medical personnel or medical facilities involved in my care to release to Community Long Term Care any medical information regarding my diagnoses and recommended treatment.

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

I understand if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the statewide Alzheimer's Disease and Related Disorders Registry, and I, or my responsible party, may be contacted for additional information.

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

____

____

____

This consent shall remain in effect until ______________________________, revoked by me in writing, or until such time as my case is closed by Community Long Term Care.

Date: ______________________ ____
Signature of Client or Responsible Party

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

Date: ______________________ ____
Signature of Witness

DHHS Form 121 (Revised 10/02)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Department of Health and Human Services
Preadmission Screening and Resident Review (PASRR)

LEVEL I PASRR SCREENING TOOL

For serious mental illness and/or intellectual disability or related disability

Preadmission screening and resident review (PASRR) is a federal requirement documented in the Code of Federal Regulations, Title 42, Part 483, Subpart C. PASRR is a process to identify people with a serious mental illness, intellectual disability or related disability, who apply to, or reside in, a Medicaid-certified nursing facility to ensure that nursing facility admission is appropriate. PASRR is also intended to ensure that people with a serious mental illness, intellectual disability or related disability are receiving all the necessary specialized services.

This screening must be completed for **ALL** persons applying for admission to a Title XIX-certified nursing facility (facility that accepts Medicaid), regardless of the payment source for the nursing facility services AND the individual's known diagnosis.

Applicant's legal name *(print)* ____

Social Security number ______________________ **Date of birth** ______________________

Medicaid identification number *(If applicable.)* ______________________

Date of review______________

Present location of applicant being evaluated ______________________

☐ Nursing facility ☐ Hospital ☐ Home ☐ Assisted living facility ☐ Group home ☐ Other

List all medical diagnoses. *(Do not include ICD codes.)* ______________________________

____

____

____

____

____

____

____

Applicant's Name ___________________________________

Section 1: Mental Illness

Mental illness or suspected serious mental illness *(Check all that apply.)*

☐ Anxiety

☐ Bipolar disorder

☐ Delusional disorder

☐ Dissociative disorder

☐ Major depressive disorder

☐ Obsessive-compulsive disorder

☐ Panic disorder

☐ Personality disorder

☐ Psychotic disorder

☐ Post-traumatic stress disorder

☐ Schizoaffective disorder

☐ Schizophrenia

☐ Somatic symptom disorder

☐ Substance abuse

☐ Other mental health diagnosis/disorder that may result in disability *(Specify.):* ______________________

A. Has the applicant shown any of the following behaviors? *(Check all that apply.)*

Self-injurious or self-mutilating behaviors *(Check all that apply.)*

☐ Danger to others, aggressive, assaultive

☐ Danger to self, suicidal ideation, threats or attempts

☐ Serious loss of interest in things that used to be pleasurable

Interpersonal functioning *(Check all that apply.)*

☐ Serious difficulty interacting appropriately and communicating effectively

☐ History of altercations ☐ History of evictions ☐ History of job loss ☐ Fear of strangers

☐ Avoidance of interpersonal relationships/social isolation

Concentration, persistence and pace *(Check all that apply.)*

☐ Serious difficulty in sustaining focused attention ☐ Serious difficulty in maintaining concentration

☐ Inability to complete simple tasks

☐ Serious difficulty in adapting to changes (agitation, exacerbated symptomology, requires intervention)

☐ Other *(Specify.):* ______________________________

Note: The individual's mental Illness must have resulted in functional limitations in major life activities within the past three to six months.

B. Has the applicant had any of the following DUE TO A MENTAL ILLNESS?

If **YES,** please provide as much of the information below as is known to you.

☐ Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization)

☐ Yes ☐ No ☐ Unknown Date: ____________________

☐ Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

☐ Yes ☐ No ☐ Unknown

☐ Law enforcement intervention.

☐ Yes ☐ No ☐ Unknown Date: ________________________

Applicant's Name ___________________________________

C. Mental illness treatments and/or services *(Check all that apply.)*

☐ Currently receiving services for mental illness ☐ Previously received services for mental illness

☐ Referred for mental illness services ☐ Additional information __________________________________

If **YES,** then provide the name of the facility/provider. ____

D. Significant change *(For nursing facility use.)*

For a significant change, indicate the **date** of the significant change.

Date: ______________________

☐ Significant change in physical or mental condition

☐ Major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff

☐ Has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both

Note: Applicants who have attempted suicide within the last two years or who may be considered a danger to self or others MUST be referred for a Level II PASRR evaluation.

Section II: Intellectual Disability Or Related Disability

A. Intellectual disability or suspected intellectual disability *(Check all that apply.)*

☐ Current diagnosis of an intellectual disability - mild, moderate, severe or profound

☐ IQ of 70 or less, if available

☐ Onset prior to 18 years of age.

Age of onset: __________

☐ Impaired adaptive behavior

Note: The presence of intellectual disability or the suspicion of intellectual disability must be referred for a Level II PASRR evaluation.

B. Related disabilities *(Check all that apply.)*

☐ Onset prior to 22 years of age.

Age of onset: _______

☐ Autism

☐ Cerebral palsy

☐ Down syndrome

☐ Epilepsy

☐ Fetal alcohol syndrome

☐ Muscular dystrophy

☐ Prader-Willi

☐ Spina bifida

☐ Traumatic brain injury

☐ Other *(Specify.)* ____________________

Functional criteria *(Check all that apply.)*

Results in substantial functional limitations in three or more major life activities.

☐ Likely to continue indefinitely

☐ Capacity for independent living

☐ Learning

☐ Mobility

☐ Self-direction

☐ Self-care

☐ Understanding and use of language

Applicant's Name ____________________________________

Finding is based on *(Check all that apply.)*

☐ Documented history ☐ Behavioral observations ☐ Individual, legal representative or family report medications

☐ Other *(Specify.)* ____

Note: If three or more of the criteria are met or these conditions result in substantial limitations that severely alter everyday functioning, they must be referred for Level II PASRR evaluation.

Section III: Other Indications for PASRR Screen Decision Making

1. Does the applicant have a primary diagnosis of dementia? ☐ Yes ☐ No
   Related neurocognitive disorder (including Alzheimer's disease)? ☐ Yes ☐ No
2. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is a serious mental Illness or intellectual disability? ☐ Yes ☐ No
3. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)? ☐ Yes ☐ No *(Check all that apply.)*

   ☐ Dementia work-up

   ☐ Comprehensive mental status exam

   ☐ Medical/functional history prior to onset

   ☐ Other (Specify.): _________________________

PASRR regulations related to a dementia diagnosis permit Level II evaluations to be **terminated** if the Level II evaluator finds the following:

1. The individual does not have mental illness, intellectual disability or a related disability.
2. The individual has a confirmed primary diagnosis of dementia, including Alzheimer's disease or a related disorder.
3. A non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness and does not have a diagnosis of intellectual disability or a related condition.

Note: The PASRR process cannot be halted if the person has an intellectual disability, regardless of the presence of dementia.

Section IV: Level I PASRR Completion

☐ **Proceed to Level II evaluation based on mental illness indicators.** *(Must have at least one of the indicators below).*

- Mental Health diagnosis + impairment + hospitalization or treatment
  Note: The individual need not have received treatment. The severity of the impairment and how recently it occurred are important, not whether the individual was hospitalized or was seen by a mental health professional.
- Suicide attempt within the last two years
- Considered to be a danger to self or others

Applicant's Name ___________________________________

☐ **Proceed to Level II evaluation based on intellectual disability Indicators**.

- The presence of an intellectual disability MUST be referred for Level II review.
- For a related disability, if three or more of the criteria are met or these conditions result in substantial limitations that severely alter everyday functioning, they must be referred for Level II PASRR.
- Note: The presence of a dementia diagnosis with intellectual disability does not cancel the need for Level II evaluation.

☐ **No further evaluation recommended, but indicators present.**
Mental health diagnosis present and controlled with medication and no impairment or hospitalizations or treatment.

☐ **No further evaluation recommended.**
No mental health diagnosis, intellectual disability or related disability, impairments or hospitalization or treatment.

Section V: Advanced Categorical Determination (SCDHHS/CLTC Use Only)

Categorical decisions and exemptions apply to people with Level II conditions to expedite decisions regarding a person's needs when a full Level II assessment is not necessary or can be delayed.

☐ The individual could not participate in or benefit from specialized services due to a comatose or semi-comatose state or functioning at brain stem level, as documented in the medical record.

☐ The individual has an illness which results in a level of physical impairment so severe the individual cannot be expected to benefit from specialized services.

☐ The individual has a diagnosis of dementia in combination with an intellectual disability or related disability. In these cases, the dementia diagnosis must be substantiated by a mini-mental state examination.

☐ The individual is being admitted to the nursing facility on a provisional basis for a period not to exceed 14 calendar days to provide respite for in-home caregivers.

☐ The individual is being admitted to the nursing facility on a provisional basis not to exceed seven calendar days while alternative arrangements can be made. The admission must be at the request of the South Carolina Department of Social Services Division of Protective Services due to suspicion of abuse or neglect on an emergency basis. The Level II evaluation must be completed within seven days of admission, on or before (date) ______________________________

☐ The individual is being admitted directly to the nursing facility from acute inpatient care for a period not to exceed 30 calendar days, as certified by the attending physician. The admission must be for treatment of the same condition that necessitated the hospitalization and must not be due to a psychiatric condition. If the individual's stay at the nursing home exceeds 30 calendar days, the Level II process **MUST** be completed by the fortieth calendar day. It is the CLTC reviewer's responsibility to monitor all assigned cases for advanced determinations and the time frame of a case for advanced determination.

******Incomplete forms will not be accepted******

Applicant's Name ___________________________________

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Information obtained from *(Check all that apply.)*
☐ Applicant ☐ Medical Records ☐ Family ☐ Other *(Specify.)*____

Screener's name *(Printed)* ____________________________

Signature ______________________________________

Credentials___________________________**Date**_________________**Phone**_______________________

Place of employment: ____

Fax _________________________ **Email** ____________________________________

Admitting nursing facility: __________________________ **Date of Admission (If known):** ________________

Note: Send accompanying documentation with completed Level I PASRR screen.

____

FOR CLTC USE ONLY

Reviewed by nurse consultant ____

Date PASRR reviewed ____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Level l Pre-Admission Screening and Resident Review (PASRR) Instructions

A. What is the purpose of PASRR Level l Screening tool?

Federal regulations (42 CFR §483.100 – 138) require all individuals applying for or residing in a Medicaid-certified nursing facility be screened to determine whether they:

1. Have serious mental illness or an intellectual disability or related disability; and if so,
2. Require the level of services provided by a nursing facility; and if so
3. Require specialized services beyond what the nursing facility may provide.

This form documents the first level of screening. If serious mental illness, intellectual disability or a related disability is identified or credibly suspected, a level II evaluation is required to confirm that identification, determine whether the individual requires nursing facility level of care and determine whether specialized services are required.

The level I PASRR Screening Tool, DHHS Form 234 February 2026, must be fully and accurately completed. Please ensure all information is **legible**. Any illegible information may result in the form being deemed inaccessible and may not be processed.

B. Demographics

Print the applicant's legal name. Enter their Social Security number and date of birth, if known. Enter their Medicaid ID number, if applicable.

Enter the date of review.

Enter applicant's present location or check the appropriate box.

List all medical diagnoses. Do not include International Classification of Diseases (ICD) codes.

Section I: Mental Illness

This section assists in identifying whether an individual has a suspected or confirmed diagnosis of serious mental illness.

This section also identifies a **significant change** which is indicated by a resident's skilled nursing facility staff for PASRR purposes. This means a major decline or improvement in the skilled nursing facility resident's status that will not normally resolve without further intervention. Further intervention could be by staff or by implementing standard disease-related clinical interventions, that impact more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both.

Section II: Intellectual Disability

This section assists in identifying whether an individual has a suspected or confirmed diagnosis of intellectual disability or a related disability.

Section III: Other Indications for PASRR Screen Decision Making

This section assists in identifying whether an individual has dementia or a related neurocognitive disorder. It also validates that there is documentation to support the diagnosis.

Section IV: PASRR Level I Completion

This section documents the first level of screening completion. If a serious mental illness, intellectual disability or a related disability is identified or credibly suspected, a level II evaluation is required to confirm that identification and determine whether specialized services are required.

Section V: Advanced Categorical Determination (SCDHHS/Community Long-Term Care (CLTC) Use Only)

This section assists in identifying whether an individual has an advanced categorical condition that would prevent the individual from benefiting from specialized mental health services. This section is reserved for SCDHHS/CLTC use only.

C. Acronyms and Abbreviations:

a. CLTC – Community Long Term Care

b. ICD - International Classification of Diseases

c. ID - Intellectual Disability

d. IQ - Intelligence Quotient

e. MI – Mental Illness

f. NF – Medicaid-certified nursing facility

g. PASRR – Preadmission Screening and Resident Review

h. PTSD – Post Traumatic Stress Disorder

i. RD – Related Disabilities

j. SCDHHS – South Carolina Department of Health and Human Services

k. SMI – Serious Mental Illness

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

Facility Name ____

Resident Name______________________________ **Social Security #**____________________

Resident Medicaid #__________________________ **Attending Physician**__________________

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

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

   - ☐ Skilled Care
   - ☐ Intermediate Care

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

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

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

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

Signature ______________________________________ **Effective Date** ____________________

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

*(Less Than Intermediate Only)

APPEALS

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

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

ALL APPEAL REQUESTS SHOULD BE SUBMITTED TO:

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

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

South Carolina Department of Health and Human Services

REQUEST FOR ASSESSMENT OF LEVEL OF CARE

From: ________________________ DHHS

____

____

To: _______________________________

____

____

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

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

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

Medicaid Worker's Signature: ______________________________ Date: ____________

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

A. Basic Infection Control Practices - 1 hour

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

B. Respecting Resident's Rights - 1 hour

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

C. Communication and Interpersonal Skills - 1 hour

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

D. Safety and Emergency Procedures - 1 hour

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

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

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

F. Principles of Observation and Reporting - 1 hour

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

Requirements of Paid Feeding Assistant Program

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

State Approval Guidelines for Paid Feeding Assistant Programs

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

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

_______________________________________   _________________________

Administrator/Coordinator Signature   **Date**

_______________________________________   _________________________

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