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
	Reasonable Effort Documentation	04/2014
	Duplicate Remittance Advice Request Form	09/2017
	Claim Reconsideration Form	11/2018
UB-04	Sample UB-04	
	Sample Remittance Advice	04/2014
	DHHS Certification of Need Psychiatric Hospital Services	10/2022
	Notice of Non-Coverage for Inpatient Psychiatric Hospital Care (two pages)	06/2014
	Sample Attestation Letter	08/2021
	Death Reporting Worksheet	01/2010
	Quarterly Seclusion and/or Restraint Reporting Form	03/2018
	Serious Occurrence Reporting Fax Form	03/2018
	Corrective Action Plan	05/2021

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

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

PROGRAM INTEGRITY

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

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

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

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

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. **Provider Name:** _____

2. **Medicaid Legacy Provider #** ☐☐☐☐☐☐
(Six Characters)

OR

3. **NPI#** ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. **Person to Contact:** _____ 5. **Telephone Number:** _____

6. **Reason for Refund:** [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. **Patient/Service Identification:**

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

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

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

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

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

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

Contact Person: _____ Phone#: _____ Date: _____

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

Beneficiary Name: _____ Date Referral Completed _____

Medicaid ID#: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ PolicyNumber _____

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

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 THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

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 -070 9 or submit an online inquiry at http :f/ www .scdhhs.gov/conta ct-us for instructions on submission of your requ est.

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 : Remitta nce 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

SCOHHS (ReVi<ed 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. 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.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Beneficiary Medicaid 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: _____
Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information

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: _____

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

Sample UB-04

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30

	31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a							a
b							b

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE _____ OF _____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample Remittance Advice

PROVIDER ID. AB00080000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 02/14/2014

PAGE 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	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
ABB1AA	1403004803012700A				27.00	6.72	P	1112233333	M CLARK				
	01		101713	71010	27.00	6.72	P			026		0.00	0.00
ABB2AA	1403004804012700A				259.00	0.00	S	1112233333	M CLARK				
	01		101713	74176	259.00	0.00	S			026		0.00	0.00
ABB3AA	1403004805012700A				24.00	0.00	R	1112233333	M CLARK			0.00	
	01		071913	A5120	12.00	0.00	R			000			0.00
	02		071913	A4927	12.00	0.00	R			000			0.00
									Edits: L00 946 L02 852 08/30/13				
	TOTALS		3		310.00							0.00	0.00

$6.72

CERT. PG TOT $0.00

MEDICAID PG TOT $286.46

CERTIFIED AMT

MEDICAID TOTAL 0.00

CHECK TOTAL

CHECK NUMBER

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

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

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

PROVIDER NAME AND ADDRESS

ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATION OF NEED

Client's Name:_____Date of Birth: _____

Social Security Number: _____

NPI or Medicaid Provider ID: _____

A review team has evaluated all of the information submitted by the physician and other professionals to justify the client's admission to_____and certifies that:

( ) Documentation of comprehensive diagnostic assessment conducted within ten (10) business days by an LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, risk assessment; and

( ) Ambulatory services available in the community do not meet the current treatment needs of the client; and

( ) Prior treatment addressing presenting concern/problem has not been successful; and

( ) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

( ) The inpatient services can reasonably be expected to improve the client's condition or prevent further regression so that the inpatient services will no longer be needed.

OR

( ) According to current criteria, the client does not meet the requirements for Medicaid-sponsored inpatient psychiatric care.

This certification is not an approval for Medicaid to pay. Medicaid eligibility or continued eligibility must be established by the appropriate SCDHHS eligibility office.

TEAM PHYSICIAN'S PRINT NAME: _____

TEAM PHYSICIAN'S SIGNATURE:_____**Date:** _____

Physician's NPI: _____

Effective Date: _____ **Check One**: Interdisciplinary Team ___ Independent Team ___

OTHER TEAM MEMBERS' SIGNATURES, TITLES, AND DATE SIGNED: (A minimum of one signature must be present.)

Date	Print Name	Signature

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 SCDHHS or its designee 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. SCDHHS' designee may serve as 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 SCDHHS or its designee at the address listed below:

SCDHHS Division of Behavioral Health
Attention: PRTF Non-Coverage
Post Office Box 8206
Columbia, SC 29202-8206

SCDHHS or its designee 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 SCDHHS or its designee review at any point during your stay or within 30 days after you receive this notice, whichever is longer.

SCDHHS or its designee will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

If SCDHHS or its designee 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 SCDHHS or its designee 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 notification from SCDHHS or its designee.

Sincerely,

Hospital Representative

cc: Beneficiary
Attending Physician
Legal Guardian
Authorized Referral Entity
SCDHHS Division of Behavioral Health, 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 Annual Attestation Form

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)]

Medicaid Provider Number and NPI

Dear <State Medicaid Director>:

Bed Size: ___ Psychiatric Beds

Number of children currently served within the PRTF who receive services based on their eligibility for the Medicaid Inpatient Psychiatric Services for children under age 21 benefit: ___

Number of children, if any, whose Medicaid Inpatient Psychiatric Services for children under age 21 benefits are paid for by any state other than South Carolina: ___

A list of all states from which the PRTF has ever received Medicaid payment for providing Inpatient psychiatric services for children under 21: _____

<Facility Name> currently meets all requirements under 42 CFR Subpart G § 483 governing the use of restraint and seclusion and also meets Certification of Need requirements as identified under 42 CFR §441 governing Subpart D — Inpatient Psychiatric Services for children under age 21 in Psychiatric Facilities Programs.

We acknowledge the right of DHEC (or its agents) and, if necessary, Centers for Medicare and Medicaid Services (CMS) to conduct an onsite survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility or to investigate serious occurrences.

<Facility Name> acknowledges that a new attestation of compliance must be submitted by my successor to SCDHHS immediately if the individual who has the legal authority to obligate the facility is no longer in such a position. SCDHHS will be notified 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 of the Facility Director>
<Printed Name>
<Title>
<Date>

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:	
Restraint/Seclusion order date/time:	

DEATH REPORTING WORKSHEET - PRTFS

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: _____

QUARTF.RLV SF.CLUSIONANO/ORRF.STRAINTRF.PORTINGFORM

TO: SCDHHS Division of Behavioral Health

Name of Facility:

Name of Repo1ting Staff:

Facility Address:

Facility Telephone:

(xxx) xx,'(-xxxx

Reporting Data

Qurut er (list specific months):

Resident Name	MedicaidTD	Staff Involved	Date of Intervention	Time In	Time Out	Location of Intervention	Ordering Physician	Type of Intervention (Seclusion or Restraint)	Reason for Intervention

Reports must be submitted electronically in a secure fo1mat to behavioralhealth004@scdhhs.gov. Deadline for submitting reports is 30 days after the end of the quarter.

Healthy Connections
MEDICAID

Henry McMaster GOVERNOR
Joshua O. Baker DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

SERIOUS OCCURRENCE REPORT FAX FORM

TO: SCDHHS Division of Behavioral Health, Fax# 803.255.8204

Name of Facility:

Name of Reporting Staff:

Facility Address:

Facility Telephone Number: xxx-xxx-xxxx

Identifying Data

Resident Name: Resident DOB:	MMIDD/YYYY
Resident Gender: □ Male □ Female □ Other	

Please attach the Serious Occurrence report to this fax cover. The following items *must* be included with the Serious Occurrence Report.

□ Name ofresident(s) involved in the serious occurrence (a separate rep01t must be submitted for each resident involved).
□ Name, street address and telephone number of the facility
□ Date and time of the occurrence
□ Place of the occurrence
□ Staff present during occurrence
□ Names!Titles of staff notified of occurrence
□ Detailed description of the occunence (include precipitating factors, identify whether seclusion or restraint was utilized, immediate actions taken, follow-up action taken)

Required Notifications

Agency/Individual	Name/Title of Person Notified	Date/Time of Notification
Protection and Advocacy		
Parent/Caregiver/Guardian		
Department of Health and Environmental Control		
Other State Agency (if applicable)		

Attach additional pages as needed.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

The Division of Behavioral Health Corrective Action Plan

Provider Name			
Contact Person		**Phone Number**	
Contact Email		**Fax Number**	
Date Submitted to SCDHHS			

Item # on Summary	Opportunity for Improvement	Corrective Action Steps to be Implemented	Person(s) Responsible for Implementation	Target Date to Implement Corrective Action	Completion Date for Implementation
1					
2					
3					
4					
5					

Additional questions to be addressed: