## FORMS

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<th>Revision Date</th>
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<td>DHHS Certification of Need Psychiatric Hospital Services</td>
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<td>Corrective Action Plan</td>
<td>05/2021</td>
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</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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#: ____________________________  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

DHHS 931 - Updated February 2018
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 1-888-289-0709 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: ______________________

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 (Rev/ed 09/01/17)
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 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: ________________________ Provider ID: ________________________ Facility/Group/Provider Name: ________________________

Return Address: Post Office Box ____________ Site ____________
Contact: ________________________ Email: ________________________ Telephone: ________________________ Fax #: ________________________

Section 3: Claim Information
Communication ID: ________________________ CCN ________________________ ☐ 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 Centers (FQHC)
☐ Home Health Services
☐ Hospice Services
☐ Hospital Services
☐ Licensed Independent Practitioner’s Rehabilitation 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 Supplemental Services (OSS)
☐ Pharmacy Services
☐ Physicians Laboratories, and other Medical Professionals
☐ Private Rehabilitation and Audiology Services
☐ Psychiatric Hospital Services
☐ Rehabilitation 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
## Sample Remittance Advice

<table>
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<tr>
<th>PROVIDER ID.</th>
<th>DEPT OF HEALTH AND HUMAN SERVICES</th>
<th>PROFESSIONAL SERVICES</th>
<th>PAYMENT DATE</th>
<th>PAGE</th>
</tr>
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<td>AB00000000</td>
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<td>REMITTANCE ADVICE</td>
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### PROFILES

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<th>CLAIM</th>
<th>SERVICE RENDERED</th>
<th>AMOUNT</th>
<th>TITLE 19</th>
<th>S</th>
<th>RECIPIENT</th>
<th>RECIPIENT NAME</th>
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<th>D</th>
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### TOTALS

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### Status Codes

<table>
<thead>
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<th>STATUS CODES</th>
<th>PROVIDER NAME AND ADDRESS</th>
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<td>ABC HEALTH PROVIDER</td>
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### Error Codes

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<th>ERROR CODES LISTED ON THIS</th>
<th>FORM REFER TO: &quot;MEDICAID&quot;</th>
<th>PROVIDER MANUAL</th>
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<tbody>
<tr>
<td></td>
<td>$0.00</td>
<td>$286.46</td>
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## Remittance Advice

For an explanation of the

- **P**: Payment Made
- **R**: Rejected
- **S**: In Process
- **E**: Encounter

**Certified Amount:**

**Medicaid Total:**

**D.H.H.S. Number:**

**Check Total:**

**Check Number:**
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.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Print Name</th>
<th>Signature</th>
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SCDHHS/CON Form 6-2014 (Revised 10/2022)
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>
<br> <Printed Name>
<br> <Title>
<br> <Date>

Updated 8/31/2021
# 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

<table>
<thead>
<tr>
<th>Type of Restraint</th>
<th>Personal</th>
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<tbody>
<tr>
<td></td>
<td>Mechanical</td>
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<tr>
<td></td>
<td>Seclusion</td>
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<tr>
<td></td>
<td>Drug used as Restraint</td>
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</table>

- **Restraint Method**
- **Reason(s) for Restraint/Seclusion use:**

- **Less restrictive methods of behavior management considered:**

- **Restraint/Seclusion order date/time:**
<table>
<thead>
<tr>
<th><strong>DEATH REPORTING WORKSHEET - PRTFS</strong></th>
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<tbody>
<tr>
<td><strong>Quote actual restraint/seclusion order(s):</strong></td>
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<tr>
<td><strong>Restraint/seclusion ordered by:</strong> Physician ______ Other Licensed Practitioner _______ and Trained in use of emergency safety interventions? Yes ______ No ________</td>
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<tr>
<td><strong>Was the resident’s treatment team physician contacted (unless same as ordering physician)</strong></td>
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<td>Yes ______ No ________</td>
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</tr>
<tr>
<td><strong>Was the resident evaluated immediately after restraint removed/removed from seclusion?</strong></td>
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<tr>
<td>Yes ______ No ________</td>
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<td></td>
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<tr>
<td><strong>Monitoring method(s), frequency, last date/time monitored:</strong></td>
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<td><strong>Last date/time of assessment:</strong></td>
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<tr>
<td><strong>Additional Information/Comments:</strong></td>
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<tr>
<td><strong>Action Information</strong></td>
</tr>
<tr>
<td><strong>Facility notifications</strong></td>
</tr>
<tr>
<td>Other agencies the provider notified (SMA, SA, etc.):</td>
</tr>
<tr>
<td>Agency/date/time: ____________________________________________</td>
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<td>Agency/date/time: ____________________________________________</td>
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<td>Agency/date/time: ____________________________________________</td>
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<tr>
<td>Agency/date/time: ____________________________________________</td>
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<tr>
<td><strong>SA Action(s)</strong></td>
</tr>
<tr>
<td>Date of receipt of restraint/seclusion death report from PRTF: ________________</td>
</tr>
<tr>
<td>Date of Survey: ________________</td>
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<tr>
<td><strong>RO Actions(s)</strong></td>
</tr>
<tr>
<td>Date of receipt of restraint/seclusion death report from PRTF: ________________</td>
</tr>
<tr>
<td>Date sent as complaint to SA (if applicable) ________________</td>
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<tr>
<td>Date/Method/Person notifying CO: ____________________________________________</td>
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<tr>
<td><strong>CO Action(s)</strong></td>
</tr>
<tr>
<td>Date of receipt of initial restraint/seclusion death report from RO: ________________</td>
</tr>
<tr>
<td>Date of receipt of restraint/seclusion death report worksheet: ________________</td>
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<tr>
<td>Person recording the information: ____________________________________________</td>
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</tbody>
</table>
QUARTERLY STRAIGHT MATTERS FORM

TO: SCDHHS Division of Behavioral Health

Name of Facility:

Name of Reporting Staff:

Facility Address: Facility Telephone: 

(XXX) XXX-XXXX

### Reporting Data

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Medicaid ID</th>
<th>Staff Involved</th>
<th>Date of Intervention</th>
<th>Time In</th>
<th>Time Out</th>
<th>Location of Intervention</th>
<th>Ordering Physician</th>
<th>Type of Intervention (Seclusion or Restraint)</th>
<th>Reason for Intervention</th>
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</thead>
<tbody>
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</tbody>
</table>

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

03/01/18
SERIOUS OCCURRENCE REPORT FAX FORM

TO:  SCDHHS Division of Behavioral Health, Fax# 803.255.8204

Name of Facility:
Name of Reporting Staff:

<table>
<thead>
<tr>
<th>Facility Address:</th>
<th>Facility Telephone Number:</th>
</tr>
</thead>
</table>

Identifying Data

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Resident DOB:</th>
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</thead>
<tbody>
<tr>
<td>Resident Gender:</td>
<td>□ Male □ Female □ Other</td>
</tr>
</tbody>
</table>

| MMDD/YYYY |

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

- □ Name of resident(s) involved in the serious occurrence (a separate report 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 occurrence (include precipitating factors, identify whether seclusion or restraint was utilized, immediate actions taken, follow-up action taken)
### Required Notifications

<table>
<thead>
<tr>
<th>Agency/Individual</th>
<th>Name/Title of Person Notified</th>
<th>Date/Time of Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protection and Advocacy</td>
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<td>Parent/Caregiver/Guardian</td>
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<td>Department of Health and Environmental Control</td>
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<tr>
<td>Other State Agency (if applicable)</td>
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</tbody>
</table>

Attach additional pages as needed.

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The Division of Behavioral Health Corrective Action Plan

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Contact Person</th>
<th>Phone Number</th>
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<table>
<thead>
<tr>
<th>Contact Email</th>
<th>Fax Number</th>
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</table>

Date Submitted to SCDHHS

<table>
<thead>
<tr>
<th>Item # on Summary</th>
<th>Opportunity for Improvement</th>
<th>Corrective Action Steps to be Implemented</th>
<th>Person(s) Responsible for Implementation</th>
<th>Target Date to Implement Corrective Action</th>
<th>Completion Date for Implementation</th>
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</thead>
<tbody>
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Additional questions to be addressed:

- 
- 
- 
- 
- 

Revision Date: May 2021