

## FORMS

<b>Number</b>	<b>Name</b>	<b>Revision Date</b>
DHHS 126	<a href="#">Confidential Complaint</a>	06/2007
DHHS 205	<a href="#">Medicaid Refunds</a>	01/2008
DHHS 931	<a href="#">Health Insurance Information Referral Form</a>	02/2018
	<a href="#">Reasonable Effort Documentation</a>	04/2014
	<a href="#">Duplicate Remittance Advice Request Form</a>	09/2017
	<a href="#">Claim Reconsideration Form</a>	11/2018
CMS-1500 (02/12)	<a href="#">Sample Claim Showing TPL Denial with NPI</a>	02/2012
	<a href="#">Sample Remittance Advice</a>	04/2014
DHHS 259	<a href="#">Interim Medicaid Targeted Case Management Transition Form w/Instructions (four pages)</a>	04/2017
	<a href="#">Freedom of Choice</a>	01/2016
	<a href="#">Freedom of Choice -Spanish</a>	01/2016
	<a href="#">Fax Cover Sheet</a>	03/2018
	<a href="#">MTCM Prior Authorization Request</a>	03/2018
	<a href="#">Parent/Caregiver/Guardian Agreement to Participate in MTCM Services</a>	01/2016
	<a href="#">Parent/Caregiver/Guardian Agreement to Participate in MTCM Services - Spanish</a>	01/2016
	<a href="#">Corrective Action Plan</a>	05/2021
	<a href="#">Targeted Case Management Referral</a>	07/2024
	<a href="#">Targeted Case Management Brief Screening</a>	07/2024



**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# \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Employer's Name/Address: \_\_\_\_\_

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

- a. beneficiary has never been covered by the policy - close insurance.
- b. beneficiary coverage ended - terminate coverage (date) \_\_\_\_\_
- c. subscriber coverage lapsed - terminate coverage (date) \_\_\_\_\_
- d. subscriber changed plans under employer - new carrier is \_\_\_\_\_  
     -new policy number is \_\_\_\_\_
- e. beneficiary to add to insurance already in MMIS for subscriber or other family member.  
     (name) \_\_\_\_\_

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

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

**Fax:**  
803-252-0870

**or**

**Mail:**  
Post Office Box 101110  
Columbia, SC 29211-9804



**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.**

**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**



**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)

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Ambulance Services</li> <li><input type="checkbox"/> Autism Spectrum Disorder (ASD) Services</li> <li><input type="checkbox"/> Clinic Services</li> <li><input type="checkbox"/> Community Long Term Care (CLTC)</li> <li><input type="checkbox"/> Community Mental Health Services</li> <li><input type="checkbox"/> Department of Disabilities and Special Needs (DDSN) Waivers</li> <li><input type="checkbox"/> Durable Medical Equipment (DME)</li> <li><input type="checkbox"/> Early Intervention Services</li> <li><input type="checkbox"/> Enhanced Services</li> <li><input type="checkbox"/> Federally Qualified Health Center (FQHC)</li> <li><input type="checkbox"/> Home Health Services</li> <li><input type="checkbox"/> Hospice Services</li> <li><input type="checkbox"/> Hospital Services</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Licensed Independent Practitioner’s Rehabilitative Services (LIPS)</li> <li><input type="checkbox"/> Local Education Agencies (LEA)</li> <li><input type="checkbox"/> Medically Complex Children’s (MCC) Waivers</li> <li><input type="checkbox"/> Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)</li> <li><input type="checkbox"/> Optional State Supplementation (OSS)</li> <li><input type="checkbox"/> Pharmacy Services</li> <li><input type="checkbox"/> Physicians Laboratories, and Other Medical Professionals<br/>Specify: _____</li> <li><input type="checkbox"/> Private Rehabilitative Therapy and Audiological Services</li> <li><input type="checkbox"/> Psychiatric Hospital Services</li> <li><input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS)</li> <li><input type="checkbox"/> Rural Health Clinic (RHC)</li> <li><input type="checkbox"/> Targeted Case Management (TCM)</li> <li><input type="checkbox"/> Other: _____</li> </ul> |
|---|--|

**Section 5: Desired Outcome**

**Request submitted by:**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

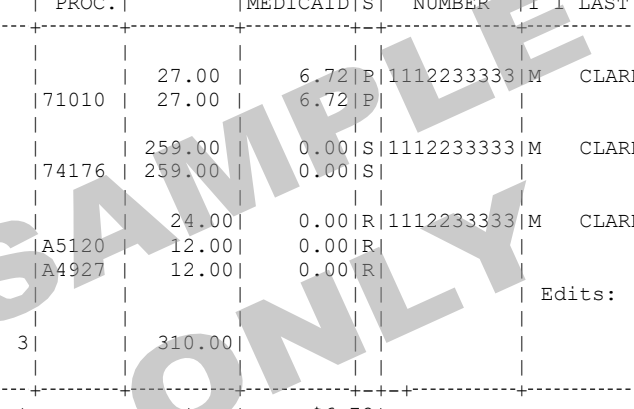
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																																									
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John A.</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1947</b>					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																																				
5. PATIENT'S ADDRESS (No., Street) <b>123 Windy Lane</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																									
CITY <b>Anytown</b>					STATE <b>SC</b>					7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																																																																																				
ZIP CODE <b>29999</b>					TELEPHONE (Include Area Code) <b>( )</b>					CITY					STATE																																																																																				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER <b>22222222B</b>																																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																															
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME <b>0.00</b>																																																																															
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME <b>401</b>																																																																															
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE <b>1</b>										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <b>Signature on File</b> DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																															
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										17b. NPI																																																																															
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>295 32</b>										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																																																																															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1										01 31 07 01 31 07 53										90801										10200										1										ZZ										1212121212																																							
2																																																																																																			
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4																																																																																																			
5																																																																																																			
6																																																																																																			
25. FEDERAL TAX I.D. NUMBER <b>55555555</b>										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. <b>DOE1234</b>										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>10200</b>										29. AMOUNT PAID \$ <b>000</b>										30. BALANCE DUE \$ <b>10200</b>																																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b. _____										33. BILLING PROVIDER INFO & PH # <b>(555) 5555555</b> <b>Local Community Mental Health Center</b> <b>111 Main Street</b> <b>Anytown, SC 22222-2222</b> a. <b>1234567890</b> b. <b>ZZ1212121212</b>																																																																															

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, suspended claim and rejected claim.

PROVIDER ID.			PROFESSIONAL SERVICES			PAYMENT DATE			PAGE	
+-----+ DEPT OF HEALTH AND HUMAN SERVICES						+-----+		+-----+		
AB00080000				REMITTANCE ADVICE		02/14/2014		1		
+-----+ SOUTH CAROLINA MEDICAID PROGRAM						+-----+		+-----+		
PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED DATE(S) PY IND MMDDYY   PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB1AA	1403004803012700A 01	101713 71010	27.00 27.00	6.72 P 6.72 P	1112233333	CLARK			0.00	0.00
ABB2AA	1403004804012700A 01	101713 74176	259.00 259.00	0.00 S 0.00 S	1112233333	CLARK			0.00	0.00
ABB3AA	1403004805012700A 01 02	071913 A5120 071913 A4927	24.00 12.00 12.00	0.00 R 0.00 R 0.00 R	1112233333	CLARK			0.00	0.00 0.00
TOTALS		3	310.00						0.00	0.00



	\$6.72			
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".	CERT. PG TOT \$0.00	MEDICAID PG TOT \$286.46	CERTIFIED AMT	MEDICAID TOTAL 0.00
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.		CHECK TOTAL		CHECK NUMBER

STATUS CODES: PROVIDER NAME AND ADDRESS

P = PAYMENT MADE | ABC HEALTH PROVIDER  
R = REJECTED |  
S = IN PROCESS | PO BOX 000000  
E = ENCOUNTER | FLORENCE SC 00000



# Sample Remittance Advice (page 3)

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

PROVIDER ID.	CLAIM	PAYMENT DATE	PAGE
DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	02/28/2014	2
AB11110000			
SOUTH CAROLINA MEDICAID PROGRAM			

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PY DATE(S) IND MMDDYY	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I	M O D	ORG CHECK DATE	ORIGINAL CCN
ABB222222	1405200077700000U		513.00	197.71	P1112233333	CLARK	M	131018	1328300224813300A
	01	100213 S0315	453.00	160.71	P			000	
	02	100213 S9445	60.00	33.00	P			000	
	TOTALS	1	513.00	193.71					

SAMPLE ONLY

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	\$243.71	0.00	0.00
		ADJUSTMENTS		
		\$193.71		
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	\$50.00	4197304	ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000

# Sample Remittance Advice (page 4)

This page of the sample Remittance Advice shows four gross-level adjustments.  
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID.	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	PAYMENT DATE	PAGE
AB11110000	SOUTH CAROLINA MEDICAID PROGRAM		02/28/2014	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	1404900004000100U	-						DEBIT	-2389.05	
TPL 4	1405500076000400U	-						DEBIT	-1949.90	
TPL 5	1404900004000100U	-						DEBIT	-477.25	
TPL 6	1405500076000400U	-						CREDIT	477.25	
PAGE TOTAL:									4338.95	0.00

PROVDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00
		ADJUSTMENTS		
		-4338.95	0.00	
	YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	0.00		ABC HEALTH PROVIDER PO BOX 000000 FLORENCE SC 00000

**Interim Medicaid Targeted Case Management Transition Form**

**Beneficiary Identification:**

Last Name	First Name	Initial
Date of Birth	Medicaid #	Provider Client #

**Current Targeted Case Management Provider:**

Agency Name	Phone Number
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Mailing Address: \_\_\_\_\_

Provider Contact Name and Fax Number \_\_\_\_\_

**Interim Beneficiary Validation or Revalidation of Existing Beneficiary:** Determine appropriate Target Group(s) and **describe** the beneficiary's behavior and circumstances which indicate the need/ medical necessity for Medicaid Targeted Case Management (MTCM) Services in the space below. The recommendation must be based on clinical information and the beneficiary's current situation. Attach supporting Psychiatric and/or Medical Assessment completed by Primary Care Physician, Psychological/Social Summary or discharge summary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Target Groups – Circle the Appropriate Target Group(s)**

*(Target Group definitions can be found in the Targeted Case Management manual on the SCDHHS Web site: <http://provider.scdhhs.gov>.)*

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Women and Children
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Similar Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

This interim form must be maintained in the beneficiary's MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

DHHS Form 259 (Revised - 04/01/17)

## Interim Medicaid Targeted Case Management Transition Form

**Medical Necessity Criteria:**

- Beneficiary would benefit from a referral to services that are necessary to diagnose, treat, cure, or prevent an illness
- Beneficiary would benefit from a referral for services that would reduce, correct or ameliorate the physical, mental, developmental, or behavioral effects of an illness, injury or disability
- Assist the beneficiary to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities;
- The beneficiary, parent or caregiver is unable to provide adequate coordination of services.
- There is a lack of food, clothing, shelter, or other concrete resources that impact the health and well-being of the beneficiary.

**Current or Past Service Providers:**

List physicians, psychologist, and staff from providers such as DSS, DJJ, Continuum of Care, DDSN, Mental Health, School for Deaf and Blind, therapist, special education, Head Start, First Steps, and Drug and Alcohol treatment. Obtain signed releases and include dates of service if known.

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I recommend that the above named Medicaid beneficiary receive MTCM service(s). The beneficiary is aware that MTCM services are not required to receive Medicaid services to address identified needs.

By my signature, I attest that the beneficiary was provided an opportunity to choose from a list of enrolled Medicaid TCM providers. (Attach a copy of the signed and dated Freedom of Choice Form.)

Printed Name	Case Manager's Signature
Title	Date

This interim form must be maintained in the beneficiary's MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

DHHS Form 259 (Revised - 04/01/17)

## **INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259 INSTRUCTIONS**

### **Purpose**

The purpose of this form is to provide a process for transitioning existing clients to the new MTCM system on or after January 1, 2013 and to also accommodate any new referrals until April 1, 2013 when the prior authorization (PA) process will be in place. The form must indicate the target group and provide the appropriate documentation to support medical necessity during the transition period from January 1, 2013 through March 31, 2013. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II implementation which will include (PA) based on documented medical necessity reviewed by SCDHHS or a quality improvement entity. The implementation for Phase II is projected to be April 1, 2013 and will include PA and the other reforms to the MTCM program.

### **Completion of transition Form 259**

The form must be completed by the case manager during the three month transition period, but no later than March 31, 2013, and placed in the beneficiary's case file. The Office of Program Integrity at SCDHHS will not audit MTCM records during this transitional period for compliance on completion of Form 259 on dates of service after January 1, 2013.

### **Beneficiary Identification** – self explanatory

### **Current Targeted Case Management Agency**

This contact information will be used for the (PA) Process once Phase II is implemented in order to notify the agency of the PA status.

### **Interim Validation/Revalidation of Existing Beneficiary**

This section should indicate if the beneficiary is a new referral or an existing beneficiary until Phase II is operational. The form should indicate the target group and provide the appropriate documentation to support medical necessity. Examples of supporting documents are provided on the form.

### **Target Groups**

Circle the arrow in the left margin to indicate the appropriate target group(s).

### **Medical Necessity Criteria**

This section is used to assist the person completing the validation portion of the form on what type of information helps define the Medical Necessity Criteria and does not require annotation.

### **Current or Past Service Providers**

If additional information is required to meet medical necessity, this section provides information to the PA reviewer on previous and current services being rendered. Past services would include those provided within the last 6 months to a year.

**INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259  
INSTRUCTIONS (Continued)**

**Freedom of Choice**

As of January 1, 2013 the following providers of MTCM include:

Department of Social Services	Department of Mental Health
Department of Disabilities and Special Needs	Department of Juvenile Justice
Department of Alcohol and Other Substance Abuse	Continuum of Care
School for the Deaf and Blind	First Steps
James R. Clark Sickle Cell Foundation	

Once other providers enroll, a list of qualified Medicaid providers geographically will be maintained on the agency web site. A Freedom of Choice form is attached.

## FREEDOM OF CHOICE

***This form should be completed after MTCM eligibility determinations have been made.***

I have been informed of the Medicaid Targeted Case Management (MTCM) services available to me or my child. I understand I have a right to choose the provider of Medicaid Targeted Case Management services, and I have been given the opportunity to choose between enrolled Medicaid providers in my community setting.

As long as I remain eligible for MTCM services, I will continue to have the opportunity to choose between qualified MTCM providers.

I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

I agree to receive Medicaid Targeted Case Management services for

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Medicaid Number

I select \_\_\_\_\_ as my provider for MTCM Services.  
Name of Provider

I decline Medicaid Targeted Case Management Services

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Medicaid Number

\_\_\_\_\_  
Signature of recipient

\_\_\_\_\_  
Date signed (month, day, year)

\_\_\_\_\_  
Signature of: (check one) \_\_\_ Family  
\_\_\_ Guardian \_\_\_ Witness

\_\_\_\_\_  
Date signed (month, day, year)

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date signed (month, day, year)

DISTRIBUTION: Original – Provider Case File

Beneficiary Copy

## LIBERTAD DE ELECCIÓN

***Este formulario debe completarse después de que se hayan realizado las determinaciones acerca de la elegibilidad para MTCM.***

He sido informado/a acerca de los servicios de la Administración de casos específicos de Medicaid (Medicaid Targeted Case Management, MTCM) que se encuentran disponibles para mí o mi hijo/a. Entiendo que tengo derecho a elegir el proveedor de servicios de la Administración de casos específicos de Medicaid y que se me ha dado la oportunidad de elegir entre proveedores inscritos de Medicaid en mi comunidad.

Mientras siga siendo elegible para los servicios de MTCM, continuaré teniendo la oportunidad de elegir entre proveedores de MTCM calificados.

Entiendo que tengo derecho a rechazar los servicios de MTCM. Si rechazo los servicios de MTCM eso no me impedirá recibir otros servicios de Medicaid para los cuales pueda calificar.

Acepto recibir los servicios de la Administración de casos específicos de Medicaid para

\_\_\_\_\_  
Nombre del beneficiario

\_\_\_\_\_  
Número de Medicaid

Selecciono a \_\_\_\_\_ como mi proveedor de servicios  
de MTCM.      Nombre del proveedor

Rechazo los servicios de la Administración de casos específicos de Medicaid.

\_\_\_\_\_  
Nombre del beneficiario

\_\_\_\_\_  
Número de Medicaid

\_\_\_\_\_  
Firma del destinatario

\_\_\_\_\_  
Fecha de firma (mes, día, año)

Firma de: (*seleccione una opción*)  
\_\_ Familiar \_\_ Tutor \_\_ Testigo

\_\_\_\_\_  
Fecha de firma (mes, día, año)

\_\_\_\_\_  
Firma del Administrador de casos

\_\_\_\_\_  
Fecha de firma (mes, día, año)

# FAX COVER SHEET

## CONFIDENTIAL INFORMATION ENCLOSED

**DATE:** \_\_\_\_\_

**TO:** SCDHHS – Division of Behavioral Health  
Attn: MTCM Prior Authorization  
Fax #: 803-255-8209

**FROM:** \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

Total Number of Pages Trans mitted: \_\_\_\_\_ (Including Cover Sheet)

### COMMENTS:

#### Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

## MTCM Prior Authorization Request

Beneficiary Information	
Name:	
Address:	
Medicaid ID #:	
Date of Birth:	
Start date MTCM services	

Provider Information	
Provider Name:	
Provider NPI:	
Address:	
City / State / Zip Code	
Phone Number	
Fax Number	

Diagnosis - Code / Description:	/
Target Population	

Procedure Code	Service Name	# of Units Requested

Rationale for Request			
What service component(s) of TCM is the PA for?			
Assessment	Case Management Plan	Referral and Linkage	Monitoring and Follow-up

**Rationale for Request**

What specific need(s) will be addressed?

Are these new or ongoing needs? If the latter, please explain what prior MTCM services were provided to address and their outcome.

Please describe specific activities that are planned to address the need(s) and estimated time frame for each specific activity

Has there been a recent change in the beneficiary's circumstances? (if yes please explain)

Has there been a recent change in case manager? (if yes, please explain)

**Disclaimer:** An authorization is not a guarantee of payment. Beneficiary must be eligible at the time services are rendered, with medical necessity being met and service must be a MTCM service. Payment of service rendered is determined by the provider's timely claim submission.



**Medicaid Targeted Case Management (MTCM)  
Parent/Caregiver/Guardian Agreement to Participate in  
MTCM Services**

Name of Beneficiary:  
Medicaid Number:

Date of Birth:

**What are Medicaid Targeted Case Management (MTCM) Services?**

Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and services identification and referral. MTCM is a time-limited process that provides an organized and structured process for moving beneficiaries toward the goal of self-sufficiency.

- The MTCM process is a shared partnership between the beneficiary's parent/caregiver/guardian and the case manager.
- Parents/Caregivers/Guardians are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources.
- MTCM ensures available resources are efficiently accessed and being used in a timely and cost effective manner.

**South Carolina Medicaid allows provision of MTCM services to the following target population(s):**

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Pregnant Women and Infants
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

**The provider has provided adequate explanation to me that my child meets criteria for the following MTCM target population group(s):**

**(Circle one)**

- 1) Yes      2) No, I need further explanation

**What does South Carolina Medicaid expect of you?**

**A.** You will be asked to:

- Whenever possible, access your child's treatment needs on your own; MTCM is **only** for when you are unable to do this on your own or with the support of family and friends.
- Participate in case management planning meetings.
- Monitor your child's case management needs and report these to your child's MTCM case manager

**B.** You will be provided with links to community resources that may support you and your family and you will be expected to reach out to those organizations.

**C.** Based on your child's needs, you may be asked to engage in other specific interventions by your child's MTCM service provider

**What can you expect of your MTCM provider?**

You can expect your provider to:

- Explain the purpose of all interventions in language that you understand
- Explain all known benefits and risks of the interventions in language that you understand
- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team

- Coordinate times and frequency of visits with you and to let you know in advance if he/she has to cancel or reschedule a visit
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to all concerns you express to them in a timely and respectful manner
- Provide information about community resources

**Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.**

By signing this form, I:

- Agree that I as parent/caregiver guardian need MTCM on behalf of my child in the following areas:
- Give permission for \_\_\_\_\_, the beneficiary, to participate in the following \_\_\_\_\_ recommended MTCM Services:
- Acknowledge that the provider has explained the target population(s) in which my child meets criteria and how he or she meets that criteria.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I further understand that services can be immediately terminated upon my request unless these services are court ordered.

\_\_\_\_\_  
Printed Name of Parent/Caregiver/Guardian

\_\_\_\_\_  
Relationship to Beneficiary

\_\_\_\_\_  
Signature of Parent/Caregiver/Guardian

\_\_\_\_\_  
Date

I hereby attest that I have provided adequate explanation of: the criteria for the identified MTCM target population to the Parent/Caregiver/Guardian; how the child meets this criteria; and (as applicable) that the child will be receiving behavioral health services.

\_\_\_\_\_  
Printed Name of Staff

\_\_\_\_\_  
Signature and Credentials of Staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Provider

## **Administración de casos específicos de Medicaid (MTCM) Acuerdo del padre/la madre/el cuidador/el tutor para participar en los servicios de MTCM**

Nombre del beneficiario:

Fecha de nacimiento:

Número de Medicaid:

### **¿Para qué sirven los servicios de Administración de casos específicos de Medicaid (MTCM)?**

Los servicios de Administración de casos específicos de Medicaid (Medicaid Targeted Case Management, MTCM) constituyen un medio para alcanzar el bienestar del beneficiario mediante la comunicación, la educación, y la identificación y la derivación de servicios. MTCM es un proceso de tiempo limitado que proporciona un proceso organizado y estructurado para ayudar a los beneficiarios a alcanzar el objetivo de la autosuficiencia.

- El proceso de MTCM constituye una asociación compartida entre el padre/la madre/el cuidador/el tutor del beneficiario y el administrador de casos.
- El padre/la madre/los cuidadores/tutores participan activamente en todas las fases del proceso (la evaluación, planificación, resolución de problemas e identificación de los recursos).
- MTCM garantiza el acceso eficiente a los recursos disponibles y que se los utilice de forma oportuna y rentable.

### **Medicaid de Carolina del Sur (South Carolina Medicaid) permite el suministro de los servicios de MTCM a la siguiente población específica:**

- Personas con discapacidades intelectuales o relacionadas.
- Niños en riesgo.
- Adultos con enfermedades mentales graves o persistentes.
- Embarazadas y bebés en riesgo.
- Personas con trastorno por el consumo de sustancias psicoactivas.
- Personas en riesgo de sufrir trastornos genéticos.
- Personas con lesiones en la cabeza o en la médula ósea y discapacidades relacionadas.
- Personas con discapacidades sensoriales.
- Adultos con discapacidades funcionales.

### **El proveedor me ha explicado de manera adecuada que mi hijo/a cumple con los requisitos para el siguiente grupo de población específica para MTCM:**

**(Encierre en un círculo una sola opción)**

- 1) Sí            2) No, necesito más explicaciones

### **¿Qué espera Medicaid de Carolina del Sur de usted?**

A. Se le pedirá que:

- Cuando sea posible, acceda por sí mismo a las necesidades de tratamiento de su hijo/a; MTCM solamente debe utilizarse para cuando usted no pueda hacerlo por sí mismo o con el apoyo de familiares o amigos.
- Participe en las reuniones de planificación de la administración de casos.
- Supervise las necesidades de administración de casos de su hijo/a e infórmelas al administrador de casos de MTCM de su hijo/a.

B. Se le proporcionará información sobre enlaces para obtener recursos de la comunidad que le puedan ayudar a usted y a su familia, y usted deberá comunicarse con esas organizaciones.

C. Con relación a las necesidades de su hijo/a, el proveedor de servicios de MTCM de su hijo/a podría pedirle que participe en otras intervenciones específicas.

### **¿Qué puede esperar usted de su proveedor de MTCM?**

Usted puede esperar que su proveedor:

- Explique el propósito de todas las intervenciones utilizando un lenguaje que usted pueda entender.
- Explique todos los beneficios y riesgos conocidos de las intervenciones utilizando un lenguaje que usted pueda entender.
- Lo trate con respeto a usted y a todos los miembros de su familia.
- Lo trate como miembro imprescindible del equipo de tratamiento.

- Coordine con usted el momento y la frecuencia de las visitas, y que le informe con anticipación si debe cancelar o reprogramar una visita.
- Analice el progreso de su hijo/a con usted en cada visita.
- Responda cualquier pregunta que usted tenga en relación con el tratamiento de su hijo/a.
- Responda a todas las inquietudes que usted exprese de manera oportuna y respetuosa.
- Le brinde información acerca de los recursos de la comunidad.

Debido a que su participación es clave para conseguir un resultado satisfactorio, cada noventa (90) días se le pedirá que confirme su voluntad para participar en estos servicios.

Al firmar este formulario, yo:

- Acepto que como padre/madre/cuidador/tutor, y en nombre de mi hijo/a, necesito los servicios de MTCM en las siguientes áreas:
- Brindo mi autorización para que \_\_\_\_\_, el beneficiario, participe en los siguientes Servicios de MTCM recomendados:
- Reconozco que el proveedor me ha explicado la población específica para la cual mi hijo/a cumple los requisitos y la manera en que él o ella cumple dichos requisitos.

Entiendo que en cualquier momento puedo informar al personal, ya sea de forma escrita o verbal, que yo (a) ya no deseo participar en estos servicios; o (b) ya no deseo que mi hijo/a reciba estos servicios. También entiendo que el suministro de los servicios puede interrumpirse de forma inmediata cuando yo lo solicite, a menos que un tribunal ordene que se brinden estos servicios.

\_\_\_\_\_  
Nombre en letra de molde del padre/madre/persona a cargo del cuidado/tutor

\_\_\_\_\_  
Relación con el beneficiario

\_\_\_\_\_  
Firma del padre/madre/persona a cargo del cuidado/tutor

\_\_\_\_\_  
Fecha

Por el presente certifico que he explicado de manera adecuada lo siguiente: los criterios de identificación para la población específica de MTCM al padre/madre/cuidador/tutor; la manera en que el niño/la niña cumple los requisitos; y (según corresponda) que el niño/la niña recibirá servicios de salud conductual.

\_\_\_\_\_  
Nombre en letra de molde del personal

\_\_\_\_\_  
Firma y credenciales del personal

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Nombre del proveedor

Henry McMaster GOVERNOR  
 Robert M. Kerr DIRECTOR  
 P.O. Box 8206 > Columbia, SC 29202  
[www.scdhhs.gov](http://www.scdhhs.gov)

### The Division of Behavioral Health Corrective Action Plan

<b>Provider Name</b>			
<b>Contact Person</b>		<b>Phone Number</b>	
<b>Contact Email</b>		<b>Fax Number</b>	
<b>Date Submitted to SCDHHS</b>			

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					

<b>Additional questions to be addressed:</b>

## Targeted Case Management Referral

### Beneficiary Information

Beneficiary Name:     
*Last First M.I.*

Beneficiary Date of Birth:  Medicaid ID:  Date of Referral:

Beneficiary Phone Number:  Beneficiary Email:

Parent/Guardian Name (If Applicable): *Last*  *First*

Diagnosis Code/s:

### Referral Instructions

- (1) Complete sections 1, 2, and 3 of the form.
- (2) The Referral Form is only valid for 90 days. If a member requires services beyond 90 days, submit a new Referral Form prior to the referral end date.

#### 1. Referral Source Information:

Provider/agency name:

Address:

Phone number:

TIN:  NPI:

Name of person completing form:

Contact information:    
*Phone E-mail*

#### 2. Referral Indicators:

Note which areas require attention (Choose as many as applicable).

- Medical  
  Social  
  Psychosocial  
  Educational  
  Vocational  
 Financial  
 Housing  
 Transportation  
 Food Insecurity  
 Other

Briefly describe the reason for referral for each indicator chosen above:

**3. Referrer Signature:**

I attest that the information on this form is true and accurate to the best of my knowledge.

Printed name

---

Signature

---

Date

## Targeted Case Management Brief Screening

### Beneficiary Information

Beneficiary Name: \_\_\_\_\_  
*Last* *First* *M.I.*

Beneficiary Date of Birth: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_ Date of Screening: \_\_\_\_\_

Beneficiary Phone Number: \_\_\_\_\_ Beneficiary Email: \_\_\_\_\_

Parent/Guardian Name (If Applicable): *Last* \_\_\_\_\_ *First* \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

### Presenting Concerns(s)/Immediate Needs

Provide a brief description of the Beneficiary's strengths, needs, and preferences in each of the following areas. If there is no presenting problem or goal in an area, note as non-applicable.

Medical:

Social:

Psychosocial:

Educational:

Vocational:

Financial:

Housing:

Transportation:

Food Insecurity:

Other:

### Other Providers or Agencies

List all other providers or agencies currently being utilized by the Beneficiary. Include the purpose of utilization and phone number, if known.

- 1.
- 2.

- 3.
- 4.
- 5.

**Supports and Services**

Note any family or friends that are a source of support:

List other sources of support in the community, such as church or other organization involvement:

If the Beneficiary is not connected to peer supports, do they want to be referred?

**Disposition**

**Case management recommended?**     Yes     No *(Inform client access to CM is available if future need arises)*

**Case Management accepted?**     Accepted     Declined

x \_\_\_\_\_

**Beneficiary Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OTHER IMMEDIATE REFERRALS MADE:** (include contact name)

Hospital/Clinic: \_\_\_\_\_ Reason: \_\_\_\_\_

Agency: \_\_\_\_\_ Reason: \_\_\_\_\_

Agency: \_\_\_\_\_ Reason: \_\_\_\_\_

Internal: \_\_\_\_\_ Reason: \_\_\_\_\_

Internal: \_\_\_\_\_ Reason: \_\_\_\_\_