

HOME AND COMMUNITY- BASED SERVICES

PROVIDER HANDBOOK

TABLE OF CONTENTS

Introduction

Chapter 1

DEPARTMENT OF PUBLIC WELFARE (DPW)

| | |
|--|---|
| Organization | 3 |
| Office of Long-Term Living (OLTL)..... | 3 |

Chapter 2

OLTL WAIVERS AND PROGRAMS

| | |
|--|----|
| Waiver and Act 150 Services | 6 |
| Service Coordination..... | 10 |
| Organized Health Care Delivery System (OHCDS)..... | 12 |
| Nursing Home Transition (NHT)..... | 12 |
| Money Follows the Person (MFP) | 13 |
| Living Independence for the Elderly (LIFE) | 15 |
| Financial Management Services (FMS) | 16 |
| Services My Way (SMW) | 17 |

Chapter 3

PARTICIPANT ELIGIBILITY AND SERVICE PLANNING

| | |
|--|----|
| Home and Community-Based Services Individual Service Plan (HCBS ISP) | 20 |
| Service Coordination Entity (SCE) Responsibilities..... | 24 |
| Participant Record Specifications..... | 24 |
| Independent Enrollment Broker (IEB)..... | 25 |
| Recipient Restriction/Centralized Lock-In Program | 26 |
| Managed Care | 27 |

Chapter 4

PROVIDER INFORMATION

| | |
|--|----|
| Provider Enrollment | 31 |
| Medicheck (Precluded Providers) List | 33 |
| Provider Eligibility..... | 35 |
| Billing Guidelines | 35 |
| Provider Access to Service Authorizations (PASA) | 40 |

Chapter 5

QUALITY MANAGEMENT

| | |
|--|----|
| Bureau of Quality and Provider Management & QMET Monitoring..... | 42 |
| Bureau of Program Integrity | 43 |

Chapter 6

SYSTEMS

| | |
|--|----|
| Home and Community Services Information System (HCSIS) | 46 |
|--|----|

| | |
|--|----|
| Incident Reporting/Enterprise Incident Management (EIM) | 47 |
| Social Assistance Management System (SAMS) | 48 |
| Provider Reimbursement & Operations Management Information System (PROMISe)..... | 49 |
| Client Information System (CIS)..... | 50 |

Appendix A:

Regulations

| | |
|--|----|
| (A)(1) § 1101 General Provisions | 53 |
| (A)(2) § 52 Long-Term Living Home and Community-Based Services | 54 |
| (A)(3) § 611 Home Care Agencies and Home Care Registries..... | 55 |
| (A)(4) § 41 Medical Assistance Provider Appeal Procedures | 56 |
| (A)(5) § 1150 MA Program Payment Policies | 57 |

Appendix B:

Policy

| | |
|---|----|
| (B)(1) Bulletin List (OLTL) | 58 |
| (B)(2) FAQs | 59 |
| (B)(3) HCBS Eligibility/Ineligibility/Change Form (PA 1768) | 60 |

Appendix C:

Provider Forms

| | |
|---|-----|
| (C)(1) OLTL Individual Service Plan..... | 65 |
| (C)(2) New Participant Web Portal Referral CHECK LIST | 69 |
| (C)(3) New Participant F/EA FMS Interim Referral Form..... | 71 |
| (C)(4) Freedom of Choice Form | 72 |
| (C)(5) Service Provider Choice Form | 74 |
| (C)(6) OLTL Service Authorization Form (MA 560) | 78 |
| (C)(7) Notice of Service Determination and the Right to Appeal (MA 561) | 80 |
| (C)(8) Bureau of Hearings and Appeals (BHA) Agency Appeal Cover Sheet | 84 |
| (C)(9) Decision to Withdraw an Appeal Request (MA 562)..... | 85 |
| (C)(10) PROMISe Provider Enrollment Base Application CHECK LIST | 86 |
| (C)(11) PROMISe Provider Enrollment Base Application | 88 |
| (C)(12) HCBS Waiver Provider Agreement | 102 |
| (C)(13) Provider Enrollment Form: COMMCARE, Independence & OBRA..... | 104 |
| (C)(14) Provider Enrollment Form: Aging Waiver | 106 |
| (C)(15) Provider Enrollment Form: Attendant Care & Act 150 | 108 |
| (C)(16) Provider Enrollment Form: Service Coordination | 109 |
| (C)(17) Provider Enrollment Form: OHCDS | 110 |
| (C)(18) Provider Disclosure Form | 112 |
| (C)(19) Ordering Forms..... | 121 |

Appendix D:

Reference & Resources

| | |
|---|-----|
| (D)(1) County Assistance Offices (CAO) Contact List | 123 |
| (D)(2) Area Agencies on Aging Map..... | 124 |
| (D)(3) Health Insurance Portability and Accountability Act (HIPAA)..... | 125 |
| (D)(4) Eligibility Verification System Quick Tips..... | 130 |
| (D)(5) Recipient Benefits..... | 132 |
| (D)(6) Utilizing Provider Resources | 133 |
| (D)(7) Rate Chart – Fee Schedule Rates | 137 |
| (D)(8) Rate Regions (4)..... | 138 |
| (D)(9) Crosswalk | 140 |
| (D)(10) Remittance Advice Sample..... | 154 |

| | |
|--------------------|-----|
| Appendix E: | |
| Glossary | 156 |
| Appendix F: | |
| Acronym List | 162 |

Introduction

The intent of this document is to be a reference manual for home and community-based service providers. It is to be used as a reference tool to assist in the day-to-day operations in the delivery of long-term care services. It does not take the place of existing policy and is not a standalone policy document. It is to be used for reference to access more detailed information on regulations and procedures required of the service provider network. Published OLTL regulations, bulletins and procedures remain the paramount guidance that service providers must follow and are the source documents on which this operational reference document has been developed. Providers must also follow specific licensure regulations and applicable local, state and federal laws. This manual does not supersede or replace regulations or policies. In addition, if this manual is in conflict with a regulation or policy, the regulations and policy supersede this manual.

Chapter 1

DEPARTMENT OF PUBLIC WELFARE

Chapter 1

DEPARTMENT OF PUBLIC WELFARE

Organization

The Department of Public Welfare consists of six executive level offices and seven different program offices. All of the offices are listed below. To learn more about each program office please explore the links below.

If you are looking to contact the Department, please email at <http://www.dpw.state.pa.us/Feedback/index.htm> or call the Helpline at 1-800-692-7462.

Executive Offices:

Secretary, Department of Public Welfare

Office of Administration
Office of the Budget
Office of General Counsel
Office of Legislative Affairs
Office of Policy Development
Office of Press and Communications

Program Offices:

Office of Child Development and Early Learning
Office of Children, Youth and Families
Office of Developmental Programs
Office of Income Maintenance
Office of Long-Term Living
Office of Medical Assistance Programs
Office of Mental Health and Substance Abuse Services

To see the most recent version and links to information on each of the Department's individual offices, click

<http://www.dpw.state.pa.us/dpworganization/index.htm>

Office of Long-Term Living

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/index.htm>

- See *“Learn More”* and *“Information For Providers”* below

The majority of people who come to us for services will need assistance with daily activities, such as bathing, dressing and meal preparation, at some point in their lives, whether due to aging, injury, illness or disability. Knowing what types of services are needed, available and how to obtain them is not easy. Services and supports available through the Pennsylvania Office of Long-Term Living (OLTL) can assist eligible individuals.

The Office of Long-Term Living helps Pennsylvanians find answers to these questions:

- What types of services and supports are available?
- Where can I find providers or caregivers?
- How do I become a provider of long-term living services?
- How will I pay for the services?

Providers may find assistance by calling the toll-free Provider Call Center at 1-800-932-0939. Information about services is available at 1-866-286-3636. Counselors will be able to provide information and refer you to the local agencies that can provide assistance with planning and arranging long-term care and services.

Learn More

- [A-Z Directory of Services](#)
- [Information for Families and Individuals](#)
- [Information for Providers](#)
- [Integrated Care for Dual Eligibles](#)
- [Long-Term Living in Pennsylvania](#)
- [Long Term Living Training Institute](#)
- [Senior Care and Services Study Commission](#)
- [Search for Long-Term Living Providers](#)

Information for Providers

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/index.htm>

- [Enterprise Incident Management \(EIM\)](#)
- [Long-Term Care Case Mix Information](#)
- [Long Term Living Training Institute](#)
- [Nursing Home Transition Program Overview](#)
- [OLTL Provider Bulletins](#)
- [Office of Medical Assistance Programs Provider Bulletins](#)
- [Order Medical Assistance Forms](#)
- [Provider Monitoring for Quality](#)

Chapter 2

OLTL WAIVERS AND PROGRAMS

Chapter 2

OLTL WAIVERS AND PROGRAMS

Waiver and Act 150 Services

MA Home and Community-Based Services (HCBS) are a set of medical and non-medical services designed to help persons with disabilities and older Pennsylvanians live independently in their homes and communities. A waiver is when the federal government “waives” the Medicaid rules for institutional care in order for Pennsylvania to use the same funds to provide supports and services for people in their own communities. DPW is the Single State Agency in Pennsylvania under Federal law, 42 U.S.C. § 1396a(a)(5), with the authority to administer Medical Assistance, including home and community-based waivers. The following sections detail the various home and community-based waivers, functional eligibility information, and services, which can be obtained through each waiver.

For information on services provided under each of the waivers, visit DPW’s website at: <http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm>

The following chart describes each of the HCBS programs that OLTL administers. Additional details on eligibility criteria and the services available in each waiver may be found in Appendices B and C of the waivers, respectively.

| Program Description | Eligibility Criteria | Services Available |
|---|--|--|
| Aging Waiver | | |
| Program provides home and community-based services to eligible persons age 60 or older who are clinically eligible for nursing facility care. | <ul style="list-style-type: none"> • U.S. citizen or permanent resident • Individuals age 60 or older • Asset limit of \$8,000 • Income limit of 300% of the federal benefit rate • Individuals must require a nursing facility level of care | <ul style="list-style-type: none"> • Accessibility Adaptations, Equipment, Technology and Medical Supplies • Adult Daily Living Services • Community Transition Services • Financial Management Services • Home Delivered Meals • Home Health Services • Non-Medical Transportation • Participant-Directed Community Supports • Participant-Directed Goods and Services |

| Program Description | Eligibility Criteria | Services Available |
|---------------------|----------------------|---|
| | | <ul style="list-style-type: none"> • Personal Assistance Services • Personal Emergency Response System (PERS) • Respite • Service Coordination • TeleCare • Therapeutic and Counseling Services |

| Program Description | Eligibility Criteria | Services Available |
|--|---|---|
| AIDS Waiver | | |
| Program provides home and community-based services to eligible persons age 21 or older who have symptomatic HIV Disease or AIDS. | <ul style="list-style-type: none"> • U.S. citizen or permanent resident • PA resident age 21 or older with symptomatic HIV or AIDS • Asset limit of \$8,000 • Income limit of 300% of federal benefit rate • Meet level of care for nursing facility (cannot be receiving Medical Assistance hospice services) | <ul style="list-style-type: none"> • Home Health Services • Nutritional Consultations • Specialized Medical Equipment and Supplies • Personal Assistance Services |

| Program Description | Eligibility Criteria | Services Available |
|---|--|---|
| Attendant Care Waiver/Act 150 | | |
| Program enables individuals with physical disabilities aged 18-59 to live in their own homes and communities. | <ul style="list-style-type: none"> • U.S. citizen or permanent resident • PA resident aged 18-59 with provisions to transition at age 60 to comparable programs seamlessly • Physical impairment expected to last for at least a continuous 12 months or that may result in death • Mentally alert and able to manage/direct own care but assistance required to complete functions of daily living, self-care and mobility • <i>Waiver</i>: Nursing facility level of care required, income limit of 300% of the federal benefit rate • Asset limit of \$8,000 • <i>Act 150 Program</i>: Nursing facility level of care not required, may | <ul style="list-style-type: none"> • Community Transition Services (Waiver only) • Financial Management Services • Participant-Directed Community Supports • Participant-Directed Goods and Services • Personal Assistance Services • Personal Emergency Response System (PERS) • Service Coordination |

| | | |
|--|---|--|
| | have income <i>or</i> resources too high for MA eligibility | |
|--|---|--|

| Program Description | Eligibility Criteria | Services Available |
|--|---|---|
| COMMCARE Waiver | | |
| <p>Program provides home and community-based services for individuals with a medically determined diagnosis of traumatic brain injury (TBI). COMMCARE prevents the institutionalization of individuals with TBI and helps them to remain as independent as possible.</p> | <ul style="list-style-type: none"> • U.S. citizen or permanent resident • PA resident age 21 and older with a diagnosis of TBI who require a nursing facility level of care • Asset limit of \$8,000 • Income limit of 300% of the federal benefit rate | <ul style="list-style-type: none"> • Accessibility, Adaptations, Equipment, Technology and Medical Supplies • Adult Daily Living • Community Integration • Community Transition Services • Financial Management Services • Home Health • Non-Medical Transportation • Personal Assistance Services • Personal Emergency Response System (PERS) • Prevocational Services • Residential Habilitation • Respite • Service Coordination • Structured Day Habilitation Services • Supported Employment • Therapeutic and Counseling Services |

| Program Description | Eligibility Criteria | Services Available |
|---|---|--|
| Independence Waiver | | |
| <p>Program provides HCBS for persons with physical disabilities to allow them to live in the community and remain as independent as possible. Also provides services to people dependent on medical technology (required to</p> | <ul style="list-style-type: none"> • U.S. citizen or permanent resident • Age 18-60 with a physical disability • Asset limit of \$8,000 • Income limit of 300% of the federal benefit rate • Disability likely to continue indefinitely and results in functional limitations in 3 or more major life activities: mobility, communication, | <ul style="list-style-type: none"> • Adult Daily Living Services • Accessibility Adaptations, Equipment, Technology and Medical Supplies • Community Integration • Community Transition Services |

| | | |
|---|--|---|
| <p>sustain life or replace vital bodily function and avert immediate threat to life).</p> | <p>self-care, self-direction, independent living, and learning</p> <ul style="list-style-type: none"> • Cannot have an intellectual disability or a major mental disorder as a primary diagnosis • Requires a nursing facility level of care | <ul style="list-style-type: none"> • Financial Management Services • Home Health • Non-Medical Transportation • Personal Assistance Services • Personal Emergency Response System (PERS) • Respite • Service Coordination • Supported Employment • Therapeutic and Counseling Services |
|---|--|---|

| Program Description | Eligibility Criteria | Services Available |
|---|---|--|
| OBRA Waiver | | |
| <p>Home and community-based services to people with developmental physical disabilities to allow them to live in the community and remain as independent as possible.</p> | <ul style="list-style-type: none"> • U.S. citizen or permanent resident • PA resident age 18-59 that requires an intermediate care facility/other related conditions (ICF/ORC) level of care • Asset limit of \$8,000 • Income limit of 300% of the federal benefit rate • Disability likely to continue indefinitely and occurred before age 22 • Disability results in 3 or more substantial functional limitations in major life activities: mobility, communication, self-care, self-direction, independent living, and learning. Cannot have intellectual disability or a major mental disorder as a primary diagnosis | <ul style="list-style-type: none"> • Adult Daily Living • Accessibility Adaptations, Equipment, Technology and Medical Supplies • Community Integration • Community Transition Services • Financial Management Services • Home Health • Non-Medical Transportation • Personal Assistance Services • Personal Emergency Response System (PERS) • Prevocational Services • Residential Habilitation Services • Respite • Service Coordination • Structured Day Habilitation Services • Supported Employment |

| | | |
|--|--|---|
| | | <ul style="list-style-type: none"> • Therapeutic and Counseling Services |
|--|--|---|

Service Coordination

Service Coordinators (SCs) perform the following core functions in assuring the quality of an HCBS waiver service plan:

- Assessment (Care Management Instrument):** Conduct an accurate evaluation of a participant’s strengths, needs, preferences, supports and desired outcomes.
- Service plan development:** Work with participants to design and modify a service plan that enables them to meet their needs, preferences and goals.
- Referral:** Provide information to help participants choose qualified providers and make arrangements to assure providers follow the service plan.

Note: SCs are to distribute the Standardized HCBS Waiver Participant Informational Materials to participants at the time of their annual redeterminations, which can be found at:
<http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinsearchresults/index.htm?po=OLTL>.

- Monitoring:** Ensure that participants get authorized services and that services meet individual needs and goals.
- Remediation:** Resolve problems when something goes wrong as well as anticipate the potential for problems.

In addition to the important work SCs do to promote quality directly with participants, they have an equally important role in **documenting** the work they do.

Good documentation:

- Allows SCs to review their work and track changes.
- Provides continuity for others who work with the individual.
- Helps SCs and agency administrators identify opportunities for quality improvement.
- Provides the evidence required by the state to meet the federal assurances.

The information SCs provide through their documentation not only provides evidence that SCs are meeting the assurances, it also affects future services.

For further information, please refer to the “Service Coordination” service definition in the waivers, for example, in the Aging or Attendant Care waivers; also reference 55 Pa. Code Chapter 52.

Service Coordinator Supervisors

Supervisors verify the accuracy and completeness of SC activities, provide technical support, manage workload across their staff, and provide administrative and other support. Audit sheets and checklists assist supervisors in auditing SC work on:

- Participant Provider Choice Forms
- Individual Service Plans
- Service notes and documentation
- Communication requirements
- Monitor service delivery
- Maintaining “tickler” files and alerts
- Checking HCSIS/SAMS entries
- Scheduled reviews, as annually assessed by regional QMETs.

Finalize and Follow up on Reported Incidents

SC supervisors must review and monitor the initial reporting, investigation, and outcomes of incidents and complaints.

Monitor Compliance with Requirements

In addition to verifying that SCs are performing individual tasks correctly, supervisors must monitor compliance with waiver requirements and ensure that they have sufficient staff to handle their participants.

In addition, OLTL requires that supervisors document personnel evaluation processes, long-range planning, training records, operational procedures, OSHA compliance, and customer satisfaction.

For additional information on service coordination please access these following resources:

<http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=05-10-06&o=N&po=OLTL&id=10/20/2010>

OR:

<http://www.ltltrainingpa.org/>

Examples of training available at this site:

PRESENTATION - Service Coordination and Enrollment Services in SAMS Webinar

PRESENTATION Individual Service Plan Review M1, M2, M3 - August 1 2012

Organized Health Care Delivery System (OHCDS)

- CMS has recommended the use of an Organized Health Care Delivery System (OHCDS) model to states in order to ensure compliance with provider agreements and direct payment requirements.
- OHCDS is defined in 42 CFR 447.10 as a public or private organization for delivering health services. The State Medicaid Manual (SMM), HCFA-Pub. 45-4, section 4442.3 also describes OHCDSs as they relate to 1915(c) waivers as follows (edited for brevity):
 - *An OHCDS must provide at least one service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. When an OHCDS is used, the provider agreement is with the OHCDS. Since it is the system itself which acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. (However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS.) When utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors.*
- Under most waivers, OLTL contracts with an intermediary (AAA or provider organization) to provide some services, and is the provider of record for those services. As the provider of record, the intermediary is responsible for validating provider qualifications of “subcontracted” providers and receives payment for the service rendered. In this respect the intermediary functions as an OHCDS provider.
- This arrangement is used by some OLTL providers. Only certain services can be provided under the OHCDS model. They are: Accessibility Adaptations; Community Transition Services; Durable Medical Equipment and Supplies; Home Delivered Meals; Non-Medical Transportation; and Personal Emergency Response System (PERS).
- OLTL has developed an OHCDS Provider Enrollment Form that allows AAAs and other provider organizations to continue intermediary billing as an OHCDS and comply with federal requirements.

For further information, please see 55 Pa. Code Chapter 51.141 and Chapter 52.53.

Also reference Appendix (C)(15) for OHCDS Provider Enrollment Form.

Nursing Home Transition (NHT) Program

<http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/nht/index.htm>

The NHT program was developed to assist and empower consumers who want to move from a nursing facility back to a home of their choice in the community and to help the Commonwealth rebalance its long-term living systems so that people have a choice of where they live and receive services. The NHT program provides the opportunity for individuals and their families or caregivers to be fully informed of all long-term living options, including the full range of home and community-based services. Individuals interested in transitioning receive the guidance and support needed to make an informed choice about their long-term living services. The program assists individuals in moving out of institutions and eliminating barriers in service systems so that individuals receive services and supports in settings of their choice.

Goals and Objectives of the NHT Program: To help rebalance the long-term living system so that people have a choice of where they live and receive services. The program:

- Enhances opportunities for individuals to move to the community by identifying individuals who wish to return to the community through the Minimum Data Set (MDS) and referrals from family, individuals, social workers, etc.
- Empowers individuals so they are involved to the extent possible in planning and directing their own transition from a nursing facility back to a home of their choice in the community.
- Develops the necessary infrastructure and supports in the community by removing barriers in the community so that individuals receive services and supports in settings of their choice.
- Expands and strengthens collaborations between organizations serving the elderly or people with disabilities to provide support and expertise to the NHT Program.

If someone resides in a nursing facility and would like to return home, support exists that can make that happen. There are Home and Community-Based Services available to help with daily living needs. Local Area Agencies on Aging, Centers for Independent Living or disability service organizations can provide information about additional resources. These resources can be used to pay for the necessary expenses to establish basic living arrangements and help individuals move into the community. Agencies may also help to locate housing, assist with home modifications and arrange for in-home care.

Please note that the Area Agency on Aging (AAA) serves individuals 60 years of age and over and individuals under the age of 60 are served by a Center for Independent Living or a disability service organization. When calling the agency, please ask to speak to the nursing home transition staff.

Money Follows the Person (MFP)

<http://www.portal.state.pa.us/portal/server.pt?open=512&objID=3950&&PageID=439648&css=L2&mode=2>

What is the Money Follows the Person Rebalancing Demonstration (MFP)?

- MFP is a federal initiative that will provide assistance to people who live in institutions so they can return to their own communities to live independently.

- It is an opportunity for states, along with advocates, family members and loved ones to join together so individuals can live as independently as possible.
- The MFP initiative focuses on a number of different groups of people, including the elderly, individuals with physical disabilities, people with developmental disability as well as people with mental illness.
- It is an initiative that will bring more federal dollars into the state that can then be used to help additional people return to their communities. It will provide additional federal funding for Pennsylvania's [Home and Community-Based Waiver Services \(HCBS\)](#).
- It is historic because it is the largest single investment in Home and Community-Based Long-Term Living Services ever offered by the federal [Centers for Medicare and Medicaid Services](#).
- Forty-two states and the District of Columbia have implemented MFP Programs. From spring 2008 through December 2011, nearly 20,000 people have transitioned back into the community through MFP Programs.
- The Affordable Care Act of 2010 strengthens and expanded the "Money Follows the Person" Program to more states. It extends the MFP Program through September 30, 2016, and appropriates an additional \$2.25 billion (\$450 million for each FY 2012-2016).

Who can participate?

In order to qualify for Money Follows the Person, individuals must:

- Have resided in a nursing facility, Intermediate Care Facility for Mental Retardation (ICF/MR) or state hospital for at least 90 days;
- Be actively receiving Medical Assistance or Medicaid benefits for at least 1 day prior to discharge/transition;
- Be transitioning to a Qualified Residence, defined by federal government as:
 - A home owned or leased by the individual or the individual's family member;
 - An apartment with an individual lease that has lockable doors (inside and out), and which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has control;
 - A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.
- Meet the eligibility criteria for one of the following state Home and Community-Based waiver programs or the LIFE program:

| | | |
|-------------------------------------|---------------------------------------|----------------------|
| Aging Waiver | Attendant Care Waiver | |
| Independence Waiver | COMMCARE Waiver | |
| OBRA Waiver | Consolidated Waiver | LIFE |

Participation: Referral/Enrollment Process, Informed Choice

Each eligible individual or the individual's authorized representative will:

- Be provided the opportunity to make an informed choice regarding participation in the MFP demonstration project.

- Choose the qualified residence in which they will reside and the setting in which they will receive home and community-based services and supports. Professional staff will be available to assist participants locate and secure a residence in the community.

Services Provided

This initiative builds upon existing services, supports and transitional efforts offered through the following Department of Public Welfare program offices:

Office of Developmental Programs
Office of Long-Term Living
Office of Mental Health and Substance Abuse Services

To get more information about Money Follows the Person contact the Office of Policy Development at **1-800-692-7462**.

LIFE (Living Independence for the Elderly) Program

<http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/lifelivingindependencefortheelderly/index.htm>

The Living Independence for the Elderly (LIFE) program offers all needed medical and supportive services to enable individuals to maintain their independence in their home as long as possible.

LIFE is a managed care program and provides a comprehensive all-inclusive package of services. The program is known nationally as the Program of All-inclusive Care for the Elderly (PACE). All of the PACE providers in Pennsylvania have the name "LIFE" in their name. The first programs were implemented in Pennsylvania in 1998.

To be eligible for LIFE, you must:

- Be age 55 or older
- Meet the level of care needs for a Nursing Facility or a Special Rehabilitation Facility
- Meet the financial requirements as determined by your local County Assistance Office or able to private pay
- Reside in an area served by a LIFE provider
- Be able to be safely served in the community as determined by a LIFE provider

Services available to you under the LIFE program include:

- Adult Day Health Services
- Audiology Services
- Dental Services
- Emergency Care
- End of Life Services
- Hospital and Nursing Facility Services

- In-home Supportive Care
- Lab and X-ray Services
- Meals
- Medical and Non-medical Transportation
- Medical Specialists
- Optometry Services and Eyeglasses
- Nursing and Medical Coverage 24/7
- Nursing Care
- Personal Care
- Pharmaceuticals
- Physical, Speech and Occupational Therapies
- Primary Medical Care
- Recreational and Socialization Activities
- Social Services
- Specialized Medical Equipment

Contacting LIFE Providers:

To find a LIFE Provider in your area, call the toll free Long-Term Living Helpline at 1-866-286-3636, or visit DPW's website at:

<http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/lifelivingindependenacefortheelderly/index.htm>

For National information on the program:

- [Centers for Medicare and Medicaid Services/PACE](#)
- [National PACE Association](#)

Financial Management Services (FMS)

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/index.htm>

Financial Management Services (FMS) are available to participants who receive participant-directed services in the Commonwealth's Medicaid §1915(c) Aging, Attendant Care, Community Care (COMMCARE), Independence and Omnibus Budget Reconciliation Act (OBRA) waivers or the state funded Attendant Care Act 150 program.

Federal Medicaid law prohibits an individual or representative from receiving Medicaid funds directly. Only Medicaid providers may receive Medicaid funds directly. Due to this requirement, a Vendor Fiscal Employer Agent (VF/EA) must perform payment-related employer responsibilities on behalf of individuals or representatives who exercise employer or budget authority.

For participants that choose to direct their services, a VF/EA organization acts as the employer agent on behalf of the participant. The fiscal support services include administrative payroll functions such as the management of federal and state income tax withholding and

employment taxes and locality taxes, processing direct care worker timesheets, brokering workers compensation insurance policies, and preparing and distributing financial reports.

A VF/EA FMS operates in accordance with §3504 of the IRS code, IRS Revenue Procedure 70-6, IRS Proposed Notice 2003-70 and REG-137036-08, as applicable.

In Pennsylvania, the fiscal support services provided by a VF/EA FMS organization include, but are not limited to:

1. Acting as a neutral “bank” for individuals’ public service funds;
2. Ensuring qualified direct care workers (DCWs) and vendors are paid in accordance with federal, state and local tax, labor and unemployment insurance laws, as applicable;
3. Preparing and distributing qualified DCWs payroll including processing DCW’s timesheets and the management of federal and state income tax withholding and employment taxes and locality taxes;
4. Verifying prospective DCWs and vendors, citizenship and alien status and ensuring that DCWs and vendors meet the qualifications for the services they are providing as per state requirements (this includes screening candidates through the precluded participation lists);
5. Processing and paying invoices for participant-directed goods and services in accordance with the participant’s individual service plan (ISP) and spending plan;
6. Processing and submitting claims and receiving Medical Assistance (MA) reimbursements and paying out for services provided by qualified DCWs and vendors in accordance with the participant’s ISP;
7. Brokering worker’s compensation insurance policies and renewals and paying premiums for individuals and representatives who are common law employers;
8. Preparing and distributing financial reports to: common law employers, Service Coordinators and OLTL as required; and
9. Providing orientation and skills training to individuals and representative acting as common law employers.

In 2013, the Office of Long-Term Living procured FMS to a single agency. For more information and updates on the transition, go to the OLTL website at: <http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/index.htm>, or to the VF/EA’s site at <https://www.publicpartnerships.com>.

Also reference Appendix (C)(2) for New Participant Web Portal Referral CHECK LIST and Appendix (C)(3) New Participant F/EA FMS Interim Referral Form.

Services My Way (SMW)

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/servicesmyway/index.htm>

Services My Way is available statewide in the Aging and Attendant Care Waiver Programs. Services My Way provides participants with greater flexibility, choice and control over their

services. Under this model, participants have the opportunity to: 1) select and manage staff that perform personal assistance type services under the Participant-Directed Community Supports service definition; 2) manage a flexible spending plan; and 3) purchase allowable goods and services through their spending plan. Under Services My Way, the participant/representative is the common-law employer of the service and support workers who they directly hire.

Participants will receive a full-range of supports, ensuring that they are successful with the participant-directed experience. Individuals choosing the SMW model will receive support from the certified VF/EA and service coordinators to assist them in their role as the common-law employer of their workers. The F/EA will:

1. Complete all necessary payroll and employment forms
2. Withhold, file and pay payroll and employment taxes
3. Process and disburse payroll
4. Broker and process payment for workers compensation on behalf of the participant
5. Certify and enroll individual providers
6. Provide training to participant on recruiting, interviewing, hiring, training, managing, and/or dismissing workers
7. Monitor spending of the spending plan

In addition, OLTL authorized service coordinators to assist in the development of each participant's spending plan. The spending plan is based on: the individual's level of care assessment, the individual service plan, budget development and the spending plan developed by the participant. Once the spending plan is developed, authorized and approved by OLTL, the participant is responsible for arranging and directing the services outlined in their plan. During the implementation and management of the spending plan, the service coordinator will:

1. Advise, train, and support the participant as needed and necessary
2. Assist with the execution and development of the spending plan
3. Assist the participant to develop an emergency back-up plan
4. Identify risks or potential risks and develop a plan to manage those risks
5. Monitor expenditures of the spending plan
6. Monitor the participant's health and welfare
7. Assist the participant to secure training of support workers who deliver services
8. Assist the participant to gain information and access to necessary services, regardless of the funding sources

Services My Way gives choice to waiver participants and improves their individual opportunities for full participation in the community. This is done by living independently in their homes, while providing for their health and safety at a cost no greater than traditional services.

SMW overview information can be found under the Aging and Attendant Care Waivers at: <http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm>.

Chapter 3

PARTICIPANT ELIGIBILITY AND SERVICE PLANNING

Chapter 3

PARTICIPANT ELIGIBILITY AND SERVICE PLANNING

Home and Community-Based Services Individual Service Plan (HCBS ISP)

Reference OLTL Bulletin 05-10-06, "Individual Service Plan Development, Review and Implementation Procedures for OLTL HCBS."

<http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=05-10-06&o=N&po=OLTL&id=10/20/2010>

A Home and Community-Based Services Individual Service Plan (HCBS ISP) is a comprehensive written summary of an individual participant's services and supports. The development of the HCBS ISP is a collaborative process between a participant, a representative of the participant, if chosen, and the Service Coordination Entity (SCE). The process will be participant driven and the HCBS ISP must address the needs, preferences and goals of the participant.

The HCBS ISP is prepared by the Service Coordination Entity (SCE) using a participant-centered approach. To prepare the HCBS ISP, the SCE will need the Level of Care Assessment (LOCA) and the needs assessment. All LOCAs are completed by the participant's local AAA (an annual LOCA is only conducted for Aging Waiver participants).

The LOCA serves 2 purposes:

1. To determine if the consumer is clinically eligible for nursing facility services (NFCE)
2. To help the participant and the SCE determine the participant's services and supports.

The needs assessment is a tool that gathers information about the participant, their condition, situation and environment. This also assists the SCE with the development of an ISP that will meet the needs of the individual participant.

The needs assessment can be found at:

http://www.portal.state.pa.us/portal/server.pt/document/971148/cmi_pdf

If a participant has applied for Medical Assistance, the results of the clinical eligibility (LOCA) indicating that the participant is clinically eligible is forwarded to the local County Assistance Office (CAO) for financial eligibility determination. Waiver services may only be delivered after the participant has been determined both clinically and financially eligible and an approved individual service plan is in place. For information on the CAOs and applying for benefits, refer to: <http://www.dpw.state.pa.us/applyforbenefits/index.htm>.

The SCE will receive the needs assessment from the Independent Enrollment Broker (except for those participants applying for Aging Waiver services, whose LOCA and needs assessment are both completed by the AAA). The needs assessment may be pre-populated with common data from the LOCA. The Independent Enrollment Broker is a contracted statewide entity to facilitate and streamline the eligibility/enrollment process for applicants

seeking services for several Pennsylvania waivers/programs. For more information, refer to the Independent Enrollment Broker section below.

The HCBS ISP must be developed so every participant has an individualized plan. The provider of service will be required to implement and provide HCBS to the participant in the type, scope, amount, duration and frequency as specified in the HCBS ISP.

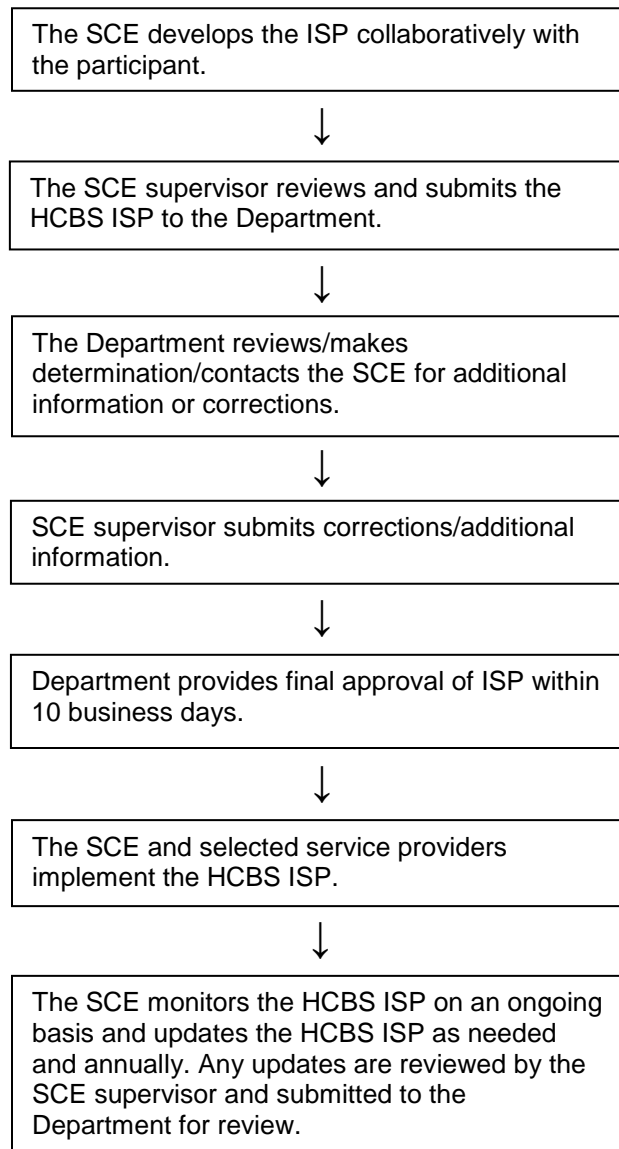
- (A) Every participant in an HCBS program shall have an individualized HCBS ISP.
- (B) The HCBS ISP will contain:
 - (1) The participant's needs.
 - (2) The participant's goals.
 - (3) The participant's outcomes.
 - (4) The HCBS, third party payer, and informal supports meeting the participant's needs, goal or outcome.
 - (5) The type, scope, amount, duration and frequency of HCBS needed by the participant.
 - (6) The provider of each HCBS.
 - (7) A participant signature.
 - (8) Risk mitigation strategies.
 - (9) Back-up plan.
 - (i) The back-up plan must contain an individualized back-up plan and an emergency back-up plan based on the individual's preferences.
 - (ii) The individualized back-up plan must outline the steps to be taken to ensure the delivery of HCBS in the case that routine HCBS are not able to be delivered.
 - (iii) The emergency back-up plan must outline steps to be taken to ensure the delivery of HCBS in the case of serious emergencies that cause a disruption of HCBS delivery.
- (C) Each identified need must be addressed by an informal support, third party payer or HCBS.
- (D) The following HCBS require a physician's prescription prior to be added to the HCBS ISP:
 - (1) Physical therapy.
 - (2) Occupational therapy.
 - (3) Speech and language therapy.
 - (4) Nursing services.

- (5) Health status and monitoring services, such as TeleCare
- (6) Durable medical equipment, as necessary.
- (E) Needs must be identified through a Departmental-approved assessment process.
- (F) The SCE must use a participant-centered assessment and process to develop the HCBS ISP.
- (G) Risks must be identified through a Departmental-approved HCBS ISP developmental process.
- (H) A SCE shall comply with the Department's statewide needs assessment and risk assessment processes required for HCBS ISP development.
- (I) The HCBS ISP shall be completed on the Department approved form.
- (J) The HCBS ISP shall be entered into the Department designated information system.
- (K) A SCE shall document the participant's progress towards outcomes and goals in the Department designated information system.
- (L) The Department or Department's designee shall approve the HCBS ISP prior to HCBS provision.
- (M) The participant's needs, goals and outcomes shall be reviewed at least annually.
- (N) The participant's needs, goals and outcomes shall be reviewed and modified, if necessary, for a participant who has a significant change in medical, financial or social condition.

HCBS ISP Process

- The SCE completes all of the information on the HCBS ISP form based on the SCE responsibilities listed above.
- The information is documented in the Home and Community Services Information System (HCSIS) or the Social Assistance Management Software (SAMS).
 - HCSIS is a comprehensive program used for managing data and supporting HCBS program. More information may be found at: <https://www.hcsis.state.pa.us/hcsis-ssd/>
 - SAMS is an extensive program capable of managing data in a streamlined, secure environment. SAMS provides integration of data and comprehensive care planning. This system is used for Aging waiver participants. More information may be found at: <http://www.lttrainingpa.org>
- The SCE supervisor reviews and submits the HCBS ISP to the Department.
- The Department reviews and makes a determination on the ISP. If additional information is required the Department will contact the SCE. The SCE will need to check HCSIS or SAMS regularly for a response or request for additional information.

Overview of the ISP Process



In the event that the SCE or the Department denies, reduces, terminates, or suspends services, the SCE will provide the participant the reason(s) for the denial in writing using the Notice of Service Determination and the Right to Appeal MA 561 Form. See Appendix (C)(7).

Please refer to the Hearings and Appeals Bulletin for additional information:

<http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=51-13-12&o=N&po=OLTL&id=12/23/2013>.

Note: Federal requirements mandate that eligibility determinations be made within 90 days.

SCE Responsibilities

1. Schedule a face-to-face meeting to develop an initial HCBS ISP with the participant within **five (5)** business days of receiving the participant's completed information, including the LOCA and needs assessment.
2. Coordinate services and supports with all third-party payers, formal and informal supports, and other community resources to assure that funding sources through the HCBS waiver are the payer of last resort and that there is no duplication of services. The SCE must document and justify the purchase of the service or product and attempts to obtain or purchase through other resources (private insurance, Medicare, State Plan and any other local resources available).
3. Authorize services or a combination of services selected or desired by the participant or the representative only when the participant's physical, cognitive, or emotional condition and overall activities of daily living (ADL) and instrumental activities of daily living (IADL) functioning require the service(s) to improve or maintain his or her functioning and/or condition.*
4. Implement and monitor the HCBS ISP consistent with timeframes and requirements of the waiver or Act 150 program.
5. Review and update the HCBS ISP at least annually within the re-evaluation due date and if the participant's needs change.

*Please refer to the OLTL Service Authorization Form Bulletin for additional information: <http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=51-13-07&o=N&po=OLTL&id=07/12/2013>. A copy of the form can be found below at Appendix (C)(6).

For more detailed information on SCE responsibilities within each waiver, visit DPW's website at: <http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm>.

Participant Record Specifications

| Program | Participant Record Specifications |
|-------------------------------|---|
| Aging Waiver | <ul style="list-style-type: none"> • A copy of and all revisions to the participant's ISP |
| AIDS Waiver | <ul style="list-style-type: none"> • Participant's individual budget (if applicable) and all budget changes (refers to SMW) |
| Attendant Care Waiver/Act 150 | <ul style="list-style-type: none"> • A copy of the physician's script obtained by the SC (not needed for the Act 150 Program) |
| COMMCARE Waiver | <ul style="list-style-type: none"> • A copy of the recertification of the need for HCBS. For all waivers, a LOCA and needs assessment must be completed at the initial enrollment. During the annual reevaluation, a needs assessment must |
| Independence Waiver | |
| LIFE Program | |

| | |
|-------------|--|
| OBRA Waiver | <p>be completed for all waiver participants, except for Aging Waiver participants, who must also receive an annual LOCA. These assessments can be either maintained electronically in SAMS for the Aging Waiver or kept in the participant's file for under 60s.</p> <ul style="list-style-type: none"> • A record of participant's MA eligibility (not needed for the Act 150 Program), including a copy of the Enrollment Application • A complete medical history of the participant including the LOCA, needs assessment, and/or other pertinent medical information • Billing invoices (refers to service coordination and any OHCDs service that the SCE is enrolled to provide) • A copy of the participant's advance directive, if executed • Updated progress notes (electronic records via HCSIS/SAMS is the standard method; OLTL accepts hard copies, but it is not required) |
|-------------|--|

Independent Enrollment Broker (IEB)

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/ieb/index.htm>

Background

The Office of Long-Term Living launched the PA Independent Enrollment Broker, effective December 1, 2010. The Independent Enrollment Broker is a contracted statewide entity to facilitate and streamline the eligibility/enrollment process for applicants seeking services for several Pennsylvania waivers/programs.

The Independent Enrollment Broker provides enrollment services for applicants with disabilities who are 18-59 years of age applying for Attendant Care, COMMCARE, Independence, OBRA, and the AIDS Waivers and the Act 150 Attendant Care Program. AAAs provide eligibility/enrollment services for applicants age 60 and over. *

The PA Independent Enrollment Broker works in close collaboration with service coordination providers to respond to needs, address issues, and ensure participants receive prompt, high quality service.

Eligibility/Enrollment Process

Participant eligibility determination is a multi-step process involving several agencies, coordinated by the PA IEB. The final decision maker regarding participant eligibility is OLTL.

Eligibility Determination Process for AIDS, Attendant Care, COMMCARE, Independence and OBRA waivers and Act 150 program:

- The PA Independent Enrollment Broker (IEB) meets with the applicant and completes a 'needs' assessment

- The AAA and CAO may begin to review eligibility prior to receiving the physician certification form
- The individual's physician completes a physician certification form
- The AAA completes a level of care assessment
- The County Assistance Office completes the financial eligibility
- OLTL determines program eligibility and enrolls the applicant or determines applicant not eligible

Following eligibility determination –

- The IEB submits information to chosen service coordination agency
- The service coordination agency completes the service plan in collaboration with the participant
- OLTL approves individual service plan

Note: When communicating with the CAO regarding consumer eligibility for waiver services, the Home and Community-Based Services (HCBS) Eligibility/Ineligibility/Change PA-1768 form should be filled out. This form should be used when a consumer is new, has changes or is a transfer. *Refer to Appendix (B)(3).*

Contact:

To begin the participant eligibility/enrollment process, please contact the PA Independent Enrollment Broker:

Toll free helpline: 877.550.4227
 Toll free TTY line: 877.824.9346
 Fax number: 717.540.6201

Address (for the central office in Harrisburg):
 PA Independent Enrollment Broker
 6385 Flank Drive, Suite 400
 Harrisburg, PA 17112-4603

*For applicants age 60 and over, contact the local AAA for eligibility/enrollment services.

Note: The IEB and AAA enrollment staff are to distribute the Standardized HCBS Waiver Participant Informational Materials to participants, which can be found at:
<http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinsearchresults/index.htm?po=OLTL>.

Recipient Restriction/Centralized Lock-In Program

DPW's Recipient Restriction/Centralized Lock-In Program restricts recipients who have been determined to be abusing and/or misusing MA services. The restriction process involves an evaluation of the degree of abuse, a determination as to whether or not the recipient should be restricted, notification of the restriction, and evaluation of subsequent medical assistance

services. DPW may not pay for a service rendered by any provider other than the one to whom the recipient is restricted, unless the services are furnished in response to an emergency or a Medical Assistance Recipient Referral Form (MA 45) is completed and submitted with the claim. The MA 45 must be obtained from the practitioner to whom the recipient is restricted.

A recipient placed in this program can be locked-in to any number of providers at one time. Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

DPW is the only entity that sets the lock-in restrictions for recipient benefits. Specifically, the Bureau of Program Integrity (BPI) is responsible for recipient reviews and restrictions.

If a recipient is restricted to a provider within a particular provider type, the EVS will notify that provider if the recipient is locked into theirs or another provider. The EVS will also indicate all type(s) of provider(s) to which the recipient is restricted.

For further information regarding violations, see 55 Pa. Code Chapter 1101.91-95 [Refer to Appendix (A)(1) of this manual].

Note: Valid emergency services are excluded from the lock-in process.

Managed Care

HealthChoices General Information

<http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/healthchoicesgeneralinformation/index.htm>

The HealthChoices Program is the name of Pennsylvania's mandatory managed care program for Medical Assistance recipients.

Through **Physical Health** Managed Care Organizations, recipients receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Department of Public Welfare's [Office of Medical Assistance Programs](#) oversees the Physical Health component of the HealthChoices Program.

Through **Behavioral Health** Managed Care Organizations, recipients receive quality medical care and timely access to appropriate mental health and/or drug and alcohol services. This component is overseen by the Department of Public Welfare's [Office of Mental Health and Substance Abuse Services](#).

HealthChoices currently serves approximately 1,225,000 recipients in the following zones:

- **Southeast Zone** - Bucks, Chester, Delaware, Montgomery and Philadelphia counties
- **Southwest Zone** - Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington and Westmoreland counties
- **Lehigh/Capital Zone** - Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York counties

- **New West Zone** - Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren counties
- **New East Zone** - Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming counties

The HealthChoices Program has three goals that guide the Department of Public Welfare in its implementation efforts. These goals are:

- To improve access to health care services for Medical Assistance recipients;
- To improve the quality of health care available to Medical Assistance recipients; and
- To stabilize Pennsylvania's Medical Assistance spending.

The HealthChoices Enrollment Program's website provides information on health plans, doctors, health care services, enrollment and more.

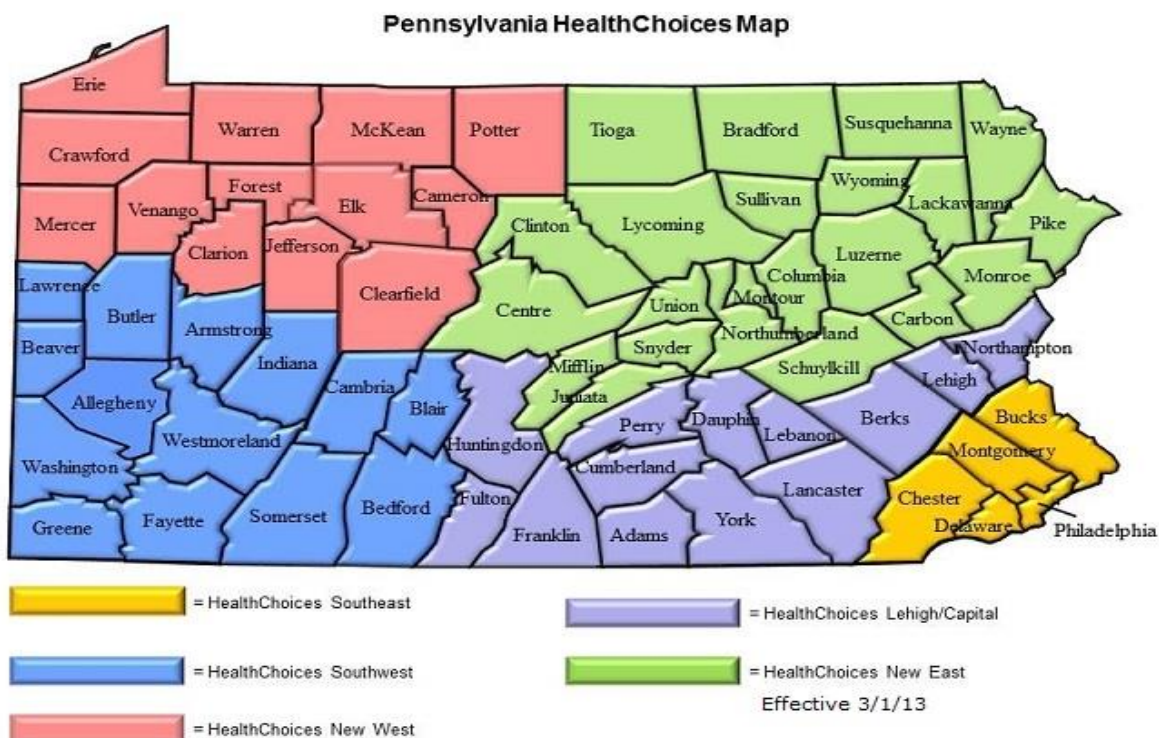
Click below to be directed to the HealthChoices Enrollment Program website:

- [External Users](#)

Statewide Managed Care Map

<http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/statewidemanagedcaremap/index.htm>

Statewide Managed Care Map (Physical/Behavioral Health)



Statewide Managed Care Map Text Links

[Statewide Managed Care - Lehigh Capital Counties](#)

Listings of HealthChoices Plans in Specific Lehigh Capital Counties

[Statewide Managed Care - New East Counties](#)

Listings of HealthChoices Plans in New East Counties

[Statewide Managed Care - New West Counties](#)

Listings of HealthChoices Plans in New West Counties

[Statewide Managed Care - Southeast Counties](#)

Listings of HealthChoices Plans in Southeast Counties

[Statewide Managed Care - Southwest Counties](#)

Listings of HealthChoices Plans in Southwest Counties

For additional information on Managed Care, visit DPW's website at:

<http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm>.

Chapter 4

PROVIDER INFORMATION

Chapter 4

PROVIDER INFORMATION

Provider Enrollment

In order for providers to participate in the Home and Community-Based Services Program, they must first enroll. To be eligible to enroll, providers in Pennsylvania must be licensed and currently registered by the appropriate state agency. Providers must be approved, licensed, issued a permit or certified by the appropriate state agency, and if applicable certified under Medicare. To enroll, providers must complete a Base Provider Enrollment form and any applicable addenda documents based on the provider type.

Before completing and submitting an application it is important that a provider determine if it qualifies to provide the services. A prospective provider must determine if it will be able to comply with the Department (Title 55, Public Welfare, Chapters 1101, 1150 and 52) and CMS rules and regulations.

It is critical that all required information is submitted with the application and provider agreement. The Department will only review complete application packages. The Department may request additional information from an applicant. Failure to comply with complete applications or information requests will result in a voided application. A voided application will occur after 30 days of receipt of the incomplete application. The Department will not return voided materials.

The table below contains links to applicable provider enrollment forms for each provider type and specialty. Print the documents for the appropriate provider type and specialty and follow the instructions for completing the documents.

Any questions about completing any of the documents, can be addressed by calling the OLTL Provider Call Center at 1-800-932-0939 and ask for the Certification and Enrollment Section.

All enrollment documents are in Adobe PDF format. A copy of Adobe Acrobat Reader must be installed on any computer system to view them.

Additional Enrollment Forms - [PROMISE™ Service Location Change Request and Instructions](#)

| | |
|--|--|
| 05 - Home Health Agency | <ul style="list-style-type: none">* Enrollment Application / Provider Agreement* Requirements / Additional Information / Forms |
| 51 - CSPPPD Provider * OBRA, COMMCARE, and Independence waivers | <ul style="list-style-type: none">* Enrollment Application / Provider Agreement* Requirements / Additional Information / Forms<ul style="list-style-type: none">* Enrollment Checklist* Region Breakdown* Regional Rate Sheet |

| | |
|--|---|
| <p>55 - Vendor</p> <p>* Aging Waiver</p> | <ul style="list-style-type: none"> * Enrollment Application / Provider Agreement * Requirements / Additional Information / Forms * Aging Waiver Provider Enrollment Application / Provider Agreement * Requirements / Additional Information <ul style="list-style-type: none"> * Enrollment Checklist * Region Breakdown * Regional Rate Sheet |
| <p>59 - Attendant Care Provider</p> <p>* includes Act 150</p> | <ul style="list-style-type: none"> * Enrollment Application / Provider Agreement * Requirements / Additional Information / Forms * Enrollment Checklist * Region Breakdown * Regional Rate Sheet |
| <p>Service Coordination Entity</p> | <ul style="list-style-type: none"> * Enrollment Application / Provider Agreement * See Appendix (C)(16) for SCE Enrollment Form |

Note: The Aging and AIDS waivers are enrolled using multiple provider types depending on the service they are providing.

For further information reference:

<http://www.dpw.state.pa.us/provider/promise/enrollmentinformation/index.htm>

In this manual, reference Appendix (C) for copies of forms.

Once an application has been processed and approved and a PROMISE number has been assigned, a newly enrolled provider will receive a computer generated enrollment letter from PROMISE, which is the Department's claims processing system.

Any changes to the approved enrollment application must be reported to the Department. This includes, but is not limited to, changes in name, email address, ownership, address, service delivery, etc. The Department must be notified 30 days prior to the effective date of the change. If circumstances prohibit a 30-day advance notice notification must be within 2 business days. Failure to provide notification may result in loss of reimbursement for each service that was provided during the overdue period.

Additional Resources for MA Providers:

[Contact Information/Help for MA Providers](#)

[Provider Contact Information Desk Reference](#)

[COMPASS: Search for Providers](#)

| | |
|---|--|
| <p>ACCESS Plus Provider Hotline Answer questions regarding ACCESS Plus Assist providers in finding specialists (i.e. dentists)</p> | <p>1-800-543-7633 Hours of operation: Monday – Friday, 7:00 AM – 8 PM, Saturday 10 AM – 2 PM</p> |
|---|--|

| | |
|--|---|
| Assist MA enrolled providers to become ACCESS Plus PCPs | |
| Bureau of Participant Operations Individual Service Plan Referrals | 717-787-8091 |
| Eligibility Verification Provides verification of MA eligibility and plan information Provides ACCESS Plus recipient PCP assignment information | 1-800-766-5387 Hours of operation: 24 hours a day, 7 days a week |
| Office of Long-Term Living (OLTL) Provider Call Center Assist with nursing facilities, ICF/MRs, OLTL waivers billing and general enrollment questions | 1-800-932-0939 Hours of operation: Monday – Thursday, 9 AM - 12 PM & 1 PM - 4 PM |
| OLTL DME Hotline Assist with nursing facility billing questions relating to DME | 1-877-299-2918 Hours of operation: Monday – Friday, 7:30 AM-4:00 PM |
| Provider Assistance Center For provider questions on electronic claims and transaction submissions and the Provider Electronic Submission (PES) software | 1-800-248-2152 or 717-975-4100 Hours of operation: Monday – Friday, 8:00 AM–5:00 PM |
| HCSIS Help Desk Provides daily support for HCSIS users who require immediate assistance with any issues they encounter while using the system. | 1-866-444-1264 Hours of operation: Monday – Friday, 8 AM-5 PM |

Medicheck (Precluded Providers) List

<http://www.dpw.state.pa.us/publications/medichecksearch/index.htm>

What is the Medicheck List?

The Medicheck List identifies providers, individuals, and other entities that are precluded from participation in the Medical Assistance (MA) Program. All listings and updates are issued through the site listed above. Previous versions of Medicheck List Bulletins can be viewed from the Medical Assistance Bulletins page on this site. The Medicheck list can be searched by provider name, license number, business name, or by using the “Search by” pull-down menu; also available is a complete Medicheck list, sorted by provider last name. Further details regarding participant exclusion can be found in MA Bulletin 99-11-05.

Why is it necessary for MA providers (both in the fee-for-service and managed care delivery systems) to use the Medicheck List?

It is necessary for providers to examine the Medicheck list to assure that an order for a service or a prescription is not initiated by individuals who are no longer permitted to participate in the

MA Program. Under applicable law, the Department and managed care organizations will not pay for any services prescribed, ordered, or rendered by the providers or individuals listed on the Medichex List, including services performed in an inpatient hospital or long-term care setting. See 55 Pa. Code Chapters 1101.42(c) and 1101.77(c) [Refer to Appendix (A)(1) of this manual]. In addition, subsequent to the effective date of the termination or preclusion, any entity of which five percent (5%) or more is owned by a sanctioned provider or individual will not be reimbursed for any items or services rendered to MA recipients. It is a provider's responsibility to utilize this on-line searchable listing to screen all employees and contractors (both individuals and entities), at the time of hire or contracting; and, thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in the state and federal health care programs.

What is the LEIE and EPLS databases, and why should providers use it in addition to the Medichex List?

The List of Excluded Individuals/Entities (LEIE), maintained by the Department of Health and Human Services, Office of Inspector General (DHHS/OIG), is a database of all individuals or entities (this would include SCEs operating in Pennsylvania) that have been excluded nationwide from participation in any federal health care program, e.g., Medicaid and Medicare. Pursuant to federal and state law, any individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. The LEIE is easy to use and can be searched and downloaded from the OIG's website at:

<https://oig.hhs.gov/exclusions/index.asp>. Although the Department makes its best efforts to include all federally excluded individuals/entities who practice in Pennsylvania on the Medichex List, providers should also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program. For the list on DPW's site see: <http://www.dpw.state.pa.us/publications/medichexsearch/index.htm>.

The Excluded Parties List System (EPLS), maintained by the General Services Administration (GSA), is a database that provides information about parties excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits. Please visit <https://www.sam.gov/portal/public/SAM/> for more information.

Are providers automatically reinstated in the Medical Assistance Program at the end of a preclusion period?

No. In accordance with 55 Pa. Code Chapter 1101.82(a) [Refer to Appendix (A)(1) of this manual], providers who have reached the end of their preclusion period must request and be re-enrolled by the Department in order to participate.

How can a potential match be confirmed?

If, after searching The Medichex list, a potential match is discovered on an individual or entity, the Bureau of Program Integrity (the Bureau) can be contacted at 717-705-6872 to assist in validating that match. Please note that the Bureau does not perform routine screenings for providers or contracted agencies hired to perform such screenings. In order to validate a potential match, the Bureau requests that a provider supply the following information via email to RA-BPI-Preclusions@pa.gov.

The name of the individual or entity

Date of Birth

Last four digits of the potential match's social security number

License number of the potential match (if applicable)
Occupation of the potential match, for example: MD, RN, Housekeeper, or Speech Therapist.

Please allow 10 business days from the Department's receipt of the request to receive a response.

Provider Eligibility

Eligibility Verification System

The Eligibility Verification System (EVS) enables providers to determine an MA recipient's eligibility as well as their scope of coverage. Please do not assume that the recipient is eligible because he/she has an ACCESS card. It is vital that a provider verifies the recipient's eligibility through EVS each time the recipient is seen. EVS should be accessed on the date the service is provided, since the recipient's eligibility is subject to change. Payment will not be made for ineligible recipients.

The purpose of EVS is to provide the most current information available regarding a recipient's MA eligibility and scope of coverage. EVS will also provide details on the recipient's third party resources, managed care plan, and/or lock-in information, when applicable.

For additional information about EVS, please reference Quick Tip #11 in the link below:
<http://www.dpw.state.pa.us/publications/forproviders/QuickTips/index.htm>

Please see Appendices (D)(5) and (D)(6) for information on participant Medical Assistance cards and benefits.

Billing Guidelines

Invoicing Options

Providers can submit claims to DPW via the 837 Institutional/UB-04 Claim Form or through electronic media claims (EMC).

Electronic Media Claims (EMC)

PA PROMISe™ can accept billing submitted on magnetic tape, diskette, compact disk (CD), through Direct Connect, through a Clearinghouse, Bulletin Board via Personal Computer (PC) modem dial up, file transfer protocol (FTP), or modem-to-modem. For more information on these invoicing options, please contact:

HP/PA PROMISe™
225 Grandview Avenue, 1st Floor
Mail Stop A-20
Camp Hill, PA 17011
Telephone: 800-248-2152 (in-state only)
717-975-4100 (local)

For information on the submitting claims electronically via the Internet, please refer to: PROMISE Provider Handbooks and Billing Guides at the link below:
<http://www.dpw.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>

To access the PROMISE website for other information such as PROMISE training, use the link below:
<https://promise.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider>

Electronic Media Claims

For claim forms submitted via any electronic media that require an attachment or attachments, you will need to obtain a Batch Cover Letter and an Attachment Control Number (ACN). Batch Cover Letters and ACNs can be obtained via the DPW PROMISE™ Internet site <http://promise.dpw.state.pa.us>, from the Provider Claim Attachment Control Window. For more information on accessing the Provider Claim Attachment Control Window, refer to the Provider Internet Users Manual found in Appendix C of the 837 Professional/CMS-1500 Claim Form Handbook.

Providers submitting claims electronically will receive an electronic Remittance Advice (RA) in the Health Care Payment and Remittance Advices (ANSI 835) format as well as a hardcopy RA Statement after each weekly cycle in which the provider's claim forms were processed. For questions concerning the information contained on the RA Statement, access Section 8 (Remittance Advice). If additional assistance is needed, contact the appropriate Provider Inquiry Unit in DPW at:

<http://www.dpw.state.pa.us/helpfultelephonenumber/contactinformationhelpformaproviders/index.htm>

Please Note: For tape-to-tape billers, the enrolled and approved Service Bureau (or the provider if producing his/her own magnetic tape) will receive a reconciliation tape after each weekly cycle in which claim forms were processed.

Payment Process

PA PROMISE™ processes financial information up to the point of payment. PA PROMISE™ does not generate actual payments to providers. The payment process is managed by the Commonwealth Treasury Department's Automated Bookkeeping System (TABS). PA PROMISE™ requests payments to be made by generating a file of payments that is sent to TABS. From there, payments can take the form of checks or Electronic Funds Transfers (EFTs). PA PROMISE™ will produce a Remittance Advice (RA) Statement for each provider who has had claims adjudicated and/or financial transactions processed during the payment cycle.

Providers have the option of receiving a check via the mail from the Treasury Department or they may utilize a direct deposit service known as the Automated Clearinghouse (ACH) Program. This service decreases the turnaround time for payment and reduces administrative costs. ACH reduces the time it takes to receive payment from DPW. Provider payments are deposited via electronic media to the bank account of the provider's choice. ACH is an

efficient and cost effective means of enhancing practice management accounts receivable procedures. ACH enrollment information can be obtained from DPW's website at:

<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepos itinformation>

Time Limits for Claim Submission

DPW must receive claim forms for submissions, resubmissions, and claim adjustment within specified time frames; otherwise, the claim will reject on timely filing related edits and will not be processed for payment. See 55 Pa. Code Chapter 1101.68(b) [Refer to Appendix (A)(1) of this manual].

Claim Adjustments

There will be times when it is necessary to correct an approved claim (i.e., a claim that has appeared on your RA Statement as "Approved") when payment was received in error.

When a claim is paid in error (overpaid or underpaid), DPW will offset/adjust future payment(s) to the provider to either:

- Recoup any money owed; or
- Compensate a provider if the provider was underpaid.

Claim adjustments can be used to:

- Correct an **overpaid** or **underpaid** claim.
- Remove a payment that was paid under the wrong recipient identification number.
- Remove a payment if the claim was submitted in error or if an unanticipated payment is received from another resource.
- Correct the patient history file with regard to co-pay.

You **cannot** use a claim adjustment to:

- Correct a rejected claim.
- Correct a pended/suspended claim.
- Correct a claim that never appeared on an RA Statement.
- Correct a recipient number or provider number.

Completing a Claim Adjustment

The CMS-1500 claim form is used to submit claims for payment as well as to submit claim adjustments when a provider is in receipt of an overpayment or underpayment. It is important to note that when submitting a claim adjustment on the CMS-1500, the claim adjustment will be completed using the provider and recipient information exactly as

entered on the original claim being adjusted. For claim line information, copy the corresponding information from the original claim for all items, which remain unchanged. Where a correction is necessary, enter the correct information.

Claim adjustments may be made to more than one claim line on a single claim adjustment. All claim lines associated with the original claim processed will be assigned a new, adjusted Internal Control Number (ICN). Consequently, an adjustment may be made to only one claim line where their lines had originally been submitted. Although only one of the claim lines may be adjusted, all claim lines will be assigned a new, adjusted ICN. If adjusting multiple claim lines from a single claim, again, all claim lines associated with the original claim will receive a new, adjusted ICN. If a claim adjustment on a previously adjusted claim needs to be submitted, it must use the *last approved ICN* to adjust another claim line on a previously adjusted claim.

Remittance Advice

(See Appendix (D)(10) for sample)

Reference Quick Tip #07 at:

<http://www.dpw.state.pa.us/publications/forproviders/QuickTips/index.htm>.

The Remittance Advice (RA) Statement explains the actions taken and the status of claims and claim adjustments processed by DPW during a daily cycle. The processing date on the RA statement is the computer processing date for the cycle. Checks corresponding to each cycle are mailed separately by the Treasury Department.

The first page of the RA is used as a mailing label and contains the “Address” where the RA is being sent. This is followed by the “Detail” page(s) that list all of the invoices processed during the PA PROMISe™ daily cycle. The next page is a “Summary” of activity from the detail page(s). Finally, the last page(s) is the Explanation of Edits Set This Cycle page(s).

Remittance Advice Address Page

The RA Address Page contains the address where the RA Statement is to be mailed and is used as a mailing label.

Providers may also find a Remittance Advice (RA) Alert on this page. From time to time, DPW may need to disseminate information quickly to the provider community. Consequently, an alert may be contained on the “Address” page of the RA Statement or in the form of an insert contained within the RA Statement.

Remittance Advice Detail Page

The detail pages of the RA statement contain information about the invoices and claim adjustments processed during the daily cycle.

Claim form information contained on the detail pages is arranged alphabetically by recipient last name. If there is more than one provider **service location code**, claims will be returned on separate RA Statements as determined by each service location.

Third Party Liability, Other Insurance and Medicare

Medical Assistance is considered the payer of last resort. All other insurance coverage must be exhausted before billing MA. The MA Program is responsible only for payment of the unsatisfied portion of the bill, up to the maximum allowable MA fee for the service as listed in the Medical Assistance Program Fee Schedule.

It is your responsibility to ask if the recipient has other coverage not identified through the EVS (i.e., Worker's Compensation, Medicare, etc.)

If other insurance coverage exists, you must bill it first. You would only bill MA for unsatisfied deductible or coinsurance amounts or if the payment you receive from the other insurance coverage is less than the MA fee for that service. In either case, MA will limit its payment to the MA fee for that service. When billing DPW after billing the other insurance, indicate the resource on the invoice as indicated in the detailed invoice instructions.

When a recipient is eligible for both Medicare and MA benefits, the Medicare program must be billed first if the service is covered by Medicare. Payment will be made by MA for the Medicare Part B deductible and coinsurance up to the MA fee.

DPW does not require that you attach insurance statements to the invoice. However, the statements must be maintained in your files and available upon request.

Duplicate copies of claims forms may be released by providers to: recipients, a recipient's personal representative who can consent to medical treatment, or an attorney or insurer with a signed authorization request. The provider shall submit a copy of the invoice and the request to the following address:

Department of Public Welfare
TPL - Casualty Unit
P.O. Box 8486
Harrisburg, PA 17105-8486
(717) 772-6604

The TPL Casualty Unit will follow-up and take appropriate action for recovery of any MA payment recouped in a settlement action.

This procedure **MUST** be followed by **ALL** providers enrolled in the MA Program for **ALL** requests for payment information about MA recipients. This includes recipients enrolled in an MCO.

Third Party Resource Identification and Recovery Procedures

When DPW discovers a potential third party resource after a claim was paid, a notification letter will be sent to the provider with detailed claim/resource billing information and an explanation of scheduled claim adjustment activity. Providers must submit documentation relevant to the claim within the time limit specified in the recovery notification. If difficulty is experienced in dealing with the third party, notify DPW at the address indicated on the recovery notice within 30 days of the deadline for resubmission. If the provider fails to respond within the time limit, the funds will be administratively recovered and the claims cannot be resubmitted for payment.

Medical Assistance Managed Care

HealthChoices is Pennsylvania's mandatory MA managed care program (see page 27). As part of DPW's commitment to ensure access to care for all MA eligible recipients, it is important that providers understand that there will always be some MA recipients in the Fee-For-Service (FFS) delivery system and that all MA recipients are issued an ACCESS card, even those in managed care. A small number of recipients are exempt from HealthChoices and will continue to access health care through the FFS delivery system. In addition, there is a time lag between initial eligibility determination and managed care organization (MCO) enrollment. During that time period, recipients must use the FFS delivery system to access care.

All HealthChoices providers are required to have a current MA provider agreement and an active Provider Identification Number as part of the HealthChoices credentialing process. Therefore, HealthChoices providers need not take any special steps to bill DPW for FFS recipients. They may simply use the current FFS billing procedures, forms and their Provider Identification Number and Service Location.

For more information on HealthChoices reference the Managed Care section of Chapter 3 of this manual.

Provider Access to Service Authorizations (PASA)

- ❖ Direct service provider organizations can access service authorization notices through the Provider Access to Service Authorizations (PASA). PASA is a web-based system that stores provider information and shares information with HCSIS. PASA is only available to SCEs with access to HCSIS (unavailable with SAMS/Aging Waiver).
- ❖ Providers have the ability to search, view, download, and print service authorization notices, which include the number of units the provider is authorized to provide to the participant.
- ❖ The ability to view service authorization notices will help facilitate and resolve billing and claims issues for providers.
 - All claims submitted through PROMISe are checked against the HCSIS system to ensure that the service and units are available.
 - By accessing PASA and reconciling their records with the information in HCSIS, providers can minimize the number of billing issues and denials.
- ❖ PASA is a valuable tool that facilitates communication with service coordinators. Since service coordinators are responsible for entering service authorizations and tracking ISPs, they can quickly and easily coordinate services with providers by referring them to the PASA.

Important Note for SCs: Service coordinators need to make sure that the Direct Service providers they are working with complete both the Provider Sign-Up form and the DPW User Agreement. In order to access the forms, please contact the HCSIS Help Desk by phone at: 1-866-444-1264 or by email at c-hcsishd@state.pa.us.

Chapter 5

QUALITY MANAGEMENT

Chapter 5

QUALITY MANAGEMENT

Bureau of Quality and Provider Management (QPM) & QMET Monitoring

The Bureau of Quality and Provider Management (QPM) is responsible for ensuring the quality of services provided to individuals served by the OLTL. As part of that responsibility, QPM has created the Quality Management Efficiency Teams (QMETs) as the primary quality provider monitoring representatives for OLTL.

Quality Management Efficiency Team

The Quality Management Efficiency Teams (QMETs) work with enrolled providers of the OLTL Medicaid waivers to efficiently balance service delivery with service compliance in a consistent manner across the Commonwealth to promote and enhance quality of service.

QMET Mission Statement: The QMET believes providers and contractors play a critical role in delivering services to citizens with long-term care needs in the Commonwealth. The QMET expects each OLTL provider and contractor to achieve compliance with established Federal and Commonwealth regulations and established waiver standards. The QMET will collaborate with providers and contractors to identify areas of needed quality improvements and assist in the implementation of the corrective action plan for continuous quality improvement. The QMET strives to work with providers and contractors to efficiently balance service delivery with service compliance in a consistent manner across the commonwealth.

Role of the QMET: To ensure the OLTL providers adhere to 55 Pa. Code Chapters 52, 1101 and 1150 (relating to Long-Term Living Home and Community-Based Services, General Provisions, and MA Program Payment Policies), follow established waiver standards, recognize and respond to changes in consumers' circumstances and achieve maximum consumer satisfaction through the process of biennial monitoring. The QMET is comprised of five regional teams. Each team consists of a Program Specialist, Social Workers, Financial Representatives, and Registered Nurses. The QMET Statewide Coordinator oversees the activities for each of the Regional teams.

Responsibility of Individual QMET Team Members: The responsibility of each QMET regional team is to work collaboratively to monitor the OLTL providers using an objective set of standards and provide technical assistance to achieve compliance with these standards. The particular knowledge base of each individual team member is used to better understand the activities occurring and not to impose a particular view of service delivery.

QMET Resources

<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/quality/qpm/management/monitoring/team/resources/index.htm>

[QMET Regional Map](#) - Pennsylvania map divided into highlighted counties for each region

[QMET Protocols](#)

[QMET State and Regional Contact Information](#)- Contact information for the QMET Statewide Coordinator and each QMET Regional Program Specialists.

[Waiver Standards Tool](#) - The attached Waiver Standards document reflects each measurement reviewed by the QMET. Each standard correlates to a specific point in the waiver.

[Fiscal/Employer Agent \(F/EA\) Financial Management Services \(FMS\) Provider Standards](#) - OLTL's Fiscal Employer Agent (F/EA) Standards

[Home and Community Based Waivers](#)

Bureau of Program Integrity

<http://www.dpw.state.pa.us/dpworganization/officeofadministration/bpi/index.htm>

The Bureau of Program Integrity (BPI) ensures Medical Assistance (MA) recipients receive quality services and that MA recipients do not abuse their use of MA services; applies administrative sanctions; refers cases of potential fraud to the appropriate enforcement agency and evaluates services rendered by MA providers and managed care organization provider networks. The Bureau monitors MA recipient overuse and abuse of services; maintains ongoing working relationships with federal and state enforcement agencies involved in monitoring potential health care fraud and abuse and ensures feedback is provided to the Department of Public Welfare (DPW) to enhance program performance. The Bureau manages the federally mandated cost containment program designed to identify the use of, and recovery from, third-party benefits available to MA recipients, and administers the Estate Recovery Program and the Health Insurance Premium Payment (HIPP) Program. *(Please reference the links below for further information on Estate Recovery).

Bureau staff includes medical professionals responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by providers of MA services, including managed care organizations, applying administrative sanctions, and referring cases of potential fraud to the appropriate enforcement agency. This responsibility includes evaluating services rendered by providers and managed care organization provider networks, monitoring recipient overuse and abuse, and maintaining ongoing working relationships with federal and state enforcement agencies involved in monitoring potential health care fraud and abuse.

To report suspected fraud or abuse of services provided under the MA Program, please call the Bureau of Program Integrity at 1-866-DPW-TIPS (1-866-379-8477), complete and submit the [MA Provider Compliance Hotline Response Form](#), or write to:

Department of Public Welfare
Office of Administration
Bureau of Program Integrity
P.O. Box 2675
Harrisburg, PA 17105-2675

Additional information about MA Fraud and Abuse can be found in the [Fraud and Abuse](#) section of this website.

In addition, the federal government has developed a set of frequently asked questions to assist providers who receive audit requests:

[Medicaid Integrity Program \(MIP\), Provider Audits - Frequently Asked Questions.](#)

Please reference OLTL Bulletin 05-11-04 , “Program Fraud & Financial Abuse in Office of Long Term Living MA Home and Community-Based Service (HCBS) Programs.”

*Further information on Estate Recovery:

[Estate Recovery Program](#)

[Estate Recovery Regulations](#)

Chapter 6

SYSTEMS

Chapter 6

SYSTEMS

HCSIS (Home and Community Services Information System)

HCSIS is a web-enabled system that can be accessed by authorized users from any computer with access to the internet. This feature allows HCSIS to serve as a central information system; in most cases, information entered into the system from the field is accessible in real-time at the central office. Each user has one or more roles in HCSIS that allow access to the system based on their specific needs and job functions. For example, a service coordinator can see the service plans and demographic information of only the participants he/she is responsible for.

HCSIS automates the collection, storage, analysis, and retrieval of information for several of the OLTL's home and community-based waivers and programs. Specifically, OLTL uses HCSIS to:

- Register new participants for programs.
- Perform service coordination tasks.
- Track service plans.
- Track provider and fiscal details.
- Verify provider payments.

Program Overview:

Within OLTL, the following programs use HCSIS:

- Attendant Care Waiver
- Act 150 Program
- COMMCARE Waiver
- OBRA Waiver
- Independence Waiver

Each of these programs has different policies and procedures that dictate how eligibility decisions are made. As OLTL standardizes the home and community-based service system, there is a need to standardize the participant records maintained in HCSIS.

The OLTL uses information from HCSIS to meet the Waiver Assurances mandated by the Centers for Medicare and Medicaid Services (CMS). The assurances were put into place by Congress to address the unique challenges of assuring the quality of services delivered to vulnerable persons living in their community. The documentation and information required in HCSIS supports the assurances and ensures that our programs continue to be supported. Service coordinators and their supervisors play an integral role in ensuring that the information in HCSIS is consistent, complete and correct. Resource information on the development of individual service plans is accessible through the Learning Management System (LMS) in HCSIS.

HCSIS is available on the Internet at: <https://www.hcsis.state.pa.us>.



Home and Community Services
Learning Management System

While there, click on the Learning Management System icon and look for this LMS sign-on screen to access tip sheets within HCSIS.

Incident Reporting/Enterprise Incident Management (EIM)

It is mandatory that administrators and employees of home health care agencies and facilities report critical incidents related to individuals who receive home and community-based services and supports from or in the agency or facility.

Administrators and employees of home health care agencies and facilities may have a local agreement that the service coordination agencies/area agencies on aging will report alleged critical incidents to OLTL. Duplicate reporting is not required.

In instances where the service coordination agency discovers or has independent knowledge of the critical incident, it is their responsibility to report to OLTL.

This applies to:

- 1) Critical incidents that occur during the time the agency or facility is providing services, **and**
- 2) Critical incidents that occur during the time the agency or facility is contracted to provide services but fails to do so, **and**
- 3) Critical incidents that occur at times other than when the agency or facility is providing or is contracted to provide services (if administrators or employees become aware of such incidents).

Participants in any service model have the right to report alleged incidents at any time. Participants are encouraged to report critical incidents because failure to do so may put them at risk. In order to protect a participant's autonomy and possible safety from an alleged perpetrator, participants are not compelled to report and no adverse consequences from OLTL will result from a participant's decision not to report. Participants shall not be terminated or threatened with loss of services because they file complaints or critical incident reports of any kind.

Further guidance is provided below on the documentation and reporting of critical incidents to OLTL. Failure to comply with this directive will result in remediation activities.

Enterprise Incident Management for Providers

Enterprise Incident Management (EIM) is a comprehensive, web-based incident and complaint reporting system that will provide the capability to record and review incidents for OLTL program participants.

Providers will use EIM to:

- Record incidents
- Investigate incidents
- Track and trend incident data for quality improvement activities

OLTL will continue to use HCSIS, as they do today, for participant, provider, plan and case management. EIM integrates with HCSIS to gather individual and provider information for use in incident reports.

Training Materials

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/eim/providers/index.htm>

EIM Provider User Training Materials

- [EIM Provider 10 Best Practices](#)
- [EIM Provider User Manual](#)
- [EIM Provider User Captivate](#)
- [EIM Glossary of Terms](#)
- [EIM Search Functionality Job Aid](#)
- [EIM SC Provider Search Overview](#)
- [EIM Incident Involving Abuse, Neglect or Exploitation Guide](#)
- [EIM Provider User Training FAQ Document](#)
- [EIM Incident and Complaint Reports Job Aid](#)
- [EIM Subject Areas Job Aid](#)
- [EIM Policy Webinar December 2011](#)
- [EIM Provider User Q&A Webinar 10142011](#)
- [EIM Provider User Q&A Webinar 10212011](#)
- [EIM Provider User Q&A Webinar 10282011](#)

EIM Provider User Role Mapping Training Materials

- [EIM Roles Job Aid](#)
- [EIM Provider Role Letter: Incident Reporter](#)
- [EIM Provider Role Letter: Incident Point Person](#)
- [EIM Provider Role Letter: Incident Read Only](#)
- [EIM Identity Manager User Manual](#)
- [EIM Role Mapping Refresher Webinar](#)

Note: EIM is currently only available to providers with access to HCSIS.

Reference OLTL Bulletin 05-11-06, "Critical Incident Management Policy for Office of Long-Term Living Home and Community-Based Services Programs."

SAMS (Social Assistance Management System)

Similar to HCSIS, SAMS was conceived to provide client tracking, but for the Pennsylvania Department of Aging (PDA). SAMS allows PDA/OLTL to collect information on individuals and their needs. Prior to SAMS, PDA was only able to collect aggregate information on the

citizens served. The statewide implementation of SAMS has instituted common terms and standards statewide. In addition to providing individual client tracking, SAMS provides functionality to support the administration and management of the AAAs.

Currently, an interface exists between HCSIS and SAMS that allows for the payment of claims for services to clients of the Department of Aging covered under the applicable waiver program. This interface consists of a nightly SAMS extract that provides consumer (a.k.a. client) and service plan data to be entered to HCSIS and subsequently used by PROMISe in the payment of claims.

SAMS stores information from the collaboration between the participant and the service coordinator. Storing the plan electronically in SAMS affords service coordinators quick accessibility to plan information. Participant service plans and the process of developing service plans is being improved as specified in the work plan.

The service coordinator gathers information on an ongoing process to assure the ISP reflects the participant's needs. Revisions are discussed with the participant and entered into SAMS and the updated service information is shared with the participant and service providers. Changes that are made to service plan information in SAMS are transferred to HCSIS on a daily basis through a nightly upload.

Resource material is available for SAMS users through the Long Term Care Training Institute (LTLTI): <http://www.ltltrainingpa.org/>.

SAMS is a web-based system that can be accessed through the Internet. In order to access SAMS, each user needs: 1) a digital security certificate installed on the individual's computer; 2) an AGENET account established and; 3) a SAMS user account established. To initiate the process to access SAMS, contact the Section Chief in the Division of Data Collection and Reporting at the Department of Aging at 717-783-0178.

PROMISe™ (Provider Reimbursement and Operations Management Information System)

The PROMISe™ Provider Portal allows providers, alternates, billing agents, and out-of-network (OON) providers with the proper security access to submit claims, verify recipient eligibility, check on claim status, and update enrollment information.

Specifically, users can use the Internet to:

- Electronically file claims for all claim types and adjustments in either a real-time or an interactive mode from any location connected to the Internet
- View the status of any claim or adjustment regardless of its method of submission
- Access computer-based training programs that will let users complete training courses from your desktop at your convenience
- Update specific provider enrollment information electronically

-Verify recipient eligibility within seconds of querying

Key Features and Benefits

The interactive features on the PROMISe™ Provider Portal provide easy access and exchange of up-to-date information between service providers and DPW. One of the immediate advantages users will realize is that they do not need to purchase, install, or develop special software or applications to use the PROMISe™ Internet application.

The PROMISe™ Internet solution allows users to log on utilizing a standard Internet browser to enter or request information. Any information users pull from this application is specific to their provider number and will not be shared with others.

If a user has an account that was already established for the PROMISe™ Provider Internet, there is no need to re-register, as their information will be migrated over to the new portal.

CIS (Client Information System)

CIS is a complex system that uses on-line and batch programs to collect, process, and store client data. CIS supports well over 1,000 programs. Daily on-line activity averages approximately 4.5 million transactions. There are approximately 1.7 million individuals actively receiving benefits through the CIS.

Data collection is supported by hundreds of on-line data collection and inquiry screens. Client data is stored in the CIS database and used to automatically determine eligibility for TANF, Food Stamps, Medicaid, the SSI-State Supplement, and State General Assistance. The system uses the results of eligibility determination to issue benefits, issue appropriate notices to applicants and recipients and to send and receive data from many other systems. Interface processes allow other systems to extract and use CIS data without requiring redundant entry of common information. To facilitate management of data, this large system is divided into subsystems each with their own screens and processes.

Client information is stored within the CIS database. Information is grouped and stored in different database areas. Application and Client Registration data is now captured in the Master Client Index, a server based application that interfaces with the CIS. Case, Budget and Individual data is stored in the Benefit Generation Area. This data is used to determine eligibility and issue benefits. The Benefit History Area supports a system record of benefits issued. The Transaction Staging Area (TSA) is a temporary area of the database that houses data before it is authorized.

CIS processes make extensive use of existing data to eliminate redundant data entry. Data is refreshed from the Master Client Index or the Benefit Generation Area or is directly data entered. Data in the TSA is in an indefinite pending state until authorized by a CAO worker. Once TSA data is authorized, it is moved to the Benefit Generation database area.

System Programs - Hundreds of action and inquiry screens and processes support the collection and viewing of client data. These programs access and update data "real time". The system is available for on-line data entry from 6:00 AM until 6:00 PM daily. At 6:00 PM

the on-line transactions are turned off for the day and hundreds more programs are executed in batch mode to issue benefits, create history, and pass data on to other systems.

APPENDICES

Appendix (A)(1)

CHAPTER 1101. GENERAL PROVISIONS

To see Chapter 1101 regulations in its entirety, click:

<http://www.pacode.com/secure/data/055/chapter1101/chap1101toc.html>

Appendix (A)(2)

[55 PA.CODE CH. 52]

LONG-TERM LIVING HOME AND COMMUNITY-BASED SERVICES

To see Chapter 52 regulations in its entirety, click:

<http://www.pacode.com/secure/data/055/chapter52/chap52toc.html>

Appendix (A)(3)

CHAPTER 611. HOME CARE AGENCIES AND HOME CARE REGISTRIES

To see Chapter 611 in its entirety, click:

<http://www.pacode.com/secure/data/028/chapter611/chap611toc.html>

Appendix (A)(4)

CHAPTER 41. MEDICAL ASSISTANCE PROVIDER APPEAL PROCEDURES

To see Chapter 41 in its entirety, click:

<http://www.pacode.com/secure/data/055/chapter41/chap41toc.html>

Appendix (A)(5)

CHAPTER 1150. MA PROGRAM PAYMENT POLICIES

To see Chapter 1150 in its entirety, click:

<http://www.pacode.com/secure/data/055/chapter1150/chap1150toc.html>

Appendix (B)(1)
Bulletin List (OLTL)

Office of Long-Term Living Bulletins

<http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinsearchresults/index.htm?po=OLTL>

Additional Resources:

[Office of Medical Assistance Program Provider Bulletins](#)

[Department of Aging Program Directives](#)

Appendix (B)(2)

FAQs

Frequently Asked Questions regarding the Long-Term Living Home and Community-Based Services regulation (55 Pa.Code Chapter 52) can be found at the following link:

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/index.htm>

Questions are based on comments received from providers.

Appendix (B)(3)

HCBS Eligibility/Ineligibility/Change Form (PA 1768)

| OFFICE INFORMATION | | | |
|---|---|--|------------------|
| County Assistance Office Name | | District Office Name | |
| Assessment Agency | | | Date |
| APPLICANT/RECIPIENT DEMOGRAPHIC INFORMATION | | | |
| Applicant / Recipient Last Name | | First Name | |
| Address | | | |
| City | State | Zip Code | Telephone Number |
| Date of Birth | | Social Security Number | |
| Name of Applicant's Representative | | | Telephone Number |
| ELIGIBILITY/PROGRAM ASSESSMENT INFORMATION | | | |
| <input type="checkbox"/> This is to verify that the individual listed has been determined to meet the level of care appropriate for Home and Community Based Services through the program indicated below. | | | |
| Assessment Date: <input style="width: 100px;" type="text"/> | | Service Begin Date: <input style="width: 100px;" type="text"/> | |
| <input type="checkbox"/> This is to verify that the individual listed does NOT meet the level of care appropriate for Home and Community Based Services through the program indicated below. | | | |
| Assessment Date: <input style="width: 100px;" type="text"/> | | | |
| <input type="checkbox"/> New Applicant <input type="checkbox"/> Change <input type="checkbox"/> Transfer <input type="checkbox"/> Termination (Complete additional information on reverse side of form for change, transfer or termination) | | | |
| <input type="checkbox"/> 38 Aging Waiver <input type="checkbox"/> 40 Attendant Care Waiver <input type="checkbox"/> 42 Independence Waiver <input type="checkbox"/> 51 Adult Community Autism Prog. (ACAP) <input type="checkbox"/> 52 Autism Waiver <input type="checkbox"/> 59 COMMCARE Waiver <input type="checkbox"/> 68 Person / Family Directed Support | <input type="checkbox"/> 70 Infants, Toddlers & Families <input type="checkbox"/> 77 Consolidated Waiver <input type="checkbox"/> 79 OBRA Waiver <input type="checkbox"/> 80 0192 Waiver <input type="checkbox"/> 96 LIFE | MFP CODES ONLY <input type="checkbox"/> 16 MFP - DOM Care <input type="checkbox"/> 17 MFP - Own Residence <input type="checkbox"/> 18 MFP - Family Member <input type="checkbox"/> 19 MFP - Group Setting | |
| AGENCY INFORMATION | | | |
| Enrolling Agency Contact Person | | Telephone Number | |
| Enrolling Agency Name and Address | | Fax Number | |
| | | E-Mail | |
| Comments | | | |
| Assessor's Signature | | Telephone Number | |

INDIVIDUAL IDENTIFICATION INFORMATION

| | |
|------|------------------|
| Name | MA Record Number |
|------|------------------|

CURRENT RESIDENT IN A LONG TERM CARE (LTC) FACILITY

| | |
|--|--|
| <input type="checkbox"/> Individual currently residing in a LTC Facility | Date of Discharge |
| LTC Facility Name | Address |
| | <input type="checkbox"/> Applying for HCBS |
| | HCBS Name: |

CURRENT ADMISSION TO A LTC FACILITY

| | |
|---|--|
| <input type="checkbox"/> Individual was admitted to LTC Facility or Personal Care Home (PCH) / Domiciliary Care (DC) Facility | Admission Date |
| | <input type="checkbox"/> Short Term Admission (Services Expected to Resume at Discharge) |
| LTC Facility or PCH/DC Facility Name | Address: |
| <input type="checkbox"/> Area Agency on Aging Office notified to initiate PCH / DC application (if applicable) | |

INFORMATION REGARDING DEATH OF AN INDIVIDUAL

| | |
|-----------------------------------|------------------|
| <input type="checkbox"/> Deceased | Date of Death |
| Contact Person | Telephone Number |

CHANGE OF ADDRESS INFORMATION – SAME COUNTY

| | |
|--|--|
| <input type="checkbox"/> Individual Moved | Date of Move |
| New Address | Telephone Number |
| <input type="checkbox"/> Services Continued | <input type="checkbox"/> Services Terminated |
| | Date of Termination |
| <input type="checkbox"/> Verification of Shelter Expenses Attached for Food Stamps | |

CHANGE OF COUNTY RESIDENCE

| | |
|---|--|
| <input type="checkbox"/> Individual Moved to _____ County | Date of Move |
| New Address | Telephone Number |
| <input type="checkbox"/> Services Continued | <input type="checkbox"/> Services Terminated |
| | Date of Termination |

TRANSFERRING HCBS PROGRAM

| | |
|--------------------------------|---------------------|
| Name of HCBS Transferring From | Services End Date |
| Name of HCBS Transferring To | Services Begin Date |

PROGRAM WITHDRAWAL INFORMATION

| | |
|--|---------------------|
| <input type="checkbox"/> Individual Voluntarily Withdrew | Date of Termination |
|--|---------------------|

TERMINATION OF HCBS PROGRAM

| | | |
|--|--------|---------------------|
| <input type="checkbox"/> HCBS Terminated | Reason | Date of Termination |
|--|--------|---------------------|

CHANGE OF INDIVIDUAL'S FINANCIAL STATUS

| |
|---|
| <input type="checkbox"/> Change in Individual's Financial Status. Documentation Attached. |
|---|

OTHER INFORMATION

| |
|--|
| <input type="checkbox"/> Other (Specify) |
|--|

**HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY / INELIGIBILITY / CHANGE FORM
INSTRUCTIONS FOR COMPLETION OF THE PA 1768**

| OFFICE INFORMATION | |
|-------------------------------|--|
| COUNTY ASSISTANCE OFFICE NAME | Enter the name of the county assistance office (CAO) where the information is being sent. |
| DISTRICT OFFICE NAME | Enter the name of the District Office where the information is being sent (if applicable). |
| ASSESSMENT AGENCY | Enter the name of the Agency conducting the assessment. |
| DATE | Enter the date (month, day and year) that the information is being sent to the CAO by the assessment agency. |

| APPLICANT/RECIPIENT DEMOGRAPHIC INFORMATION | |
|---|---|
| APPLICANT/RECIPIENT LAST NAME | Enter the individual's Last Name. |
| FIRST NAME | Enter the individual's First Name and Middle Initial. |
| ADDRESS | Enter the street address, including the apartment number where the individual resides. |
| CITY | Enter the city. |
| STATE | Enter the state. |
| ZIP CODE | Enter the zip code. |
| TELEPHONE NUMBER | Enter the individual's telephone number, including a message number (where a contact can be made to reach the applicant/recipient). |
| DATE OF BIRTH | Enter the individual's Date of Birth. |
| SOCIAL SECURITY NUMBER | Enter the individual's Social Security Number (SSN). |
| NAME OF APPLICANT'S REPRESENTATIVE | Enter the name of the individual who is completing the application on behalf of the applicant (if applicable). |
| TELEPHONE NUMBER | Enter the representative's telephone number, including a message number (where a contact can be made to reach the representative). |

| ELIGIBILITY/PROGRAM ASSESSMENT INFORMATION | |
|--|--|
| <input type="checkbox"/> THIS IS TO VERIFY THAT THE INDIVIDUAL LISTED HAS BEEN DETERMINED TO MEET THE LEVEL OF CARE APPROPRIATE FOR HOME AND COMMUNITY BASED SERVICES THROUGH THE PROGRAM INDICATED BELOW: ASSESSMENT DATE: <input type="text"/> SERVICE BEGIN DATE: <input type="text"/> | Check the box to indicate that the individual was determined eligible for HCBS. In the box enter the date that the assessment agency conducted the level of care and functional assessment and found the individual eligible for HCBS. In the box enter the date that the individual will start to receive services under a HCBS program. |
| <input type="checkbox"/> THIS IS TO VERIFY THAT THE INDIVIDUAL LISTED HAS BEEN DETERMINED NOT TO MEET THE LEVEL OF CARE APPROPRIATE FOR HOME AND COMMUNITY BASED SERVICES THROUGH THE PROGRAM INDICATED BELOW: ASSESSMENT DATE: <input type="text"/> | Check the box to indicate that the individual was determined <u>ineligible</u> for HCBS. In the box enter the date that the assessment agency conducted the level of care and functional assessment and found the individual <u>ineligible</u> for HCBS. |
| <input type="checkbox"/> NEW APPLICANT <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER <input type="checkbox"/> TERMINATION (COMPLETE INFORMATION ON REVERSE SIDE) | Check the appropriate box to indicate whether the individual is a new applicant for a HCBS or a Change, Transfer or Termination of services has occurred for an individual who is currently receiving services. For a Change, Transfer or Termination use the reverse side of the form to enter additional information. |
| <input type="checkbox"/> 38 Aging <input type="checkbox"/> 68 Per. Fam. Direct. Supp <input type="checkbox"/> 40 Attendant Care <input type="checkbox"/> 70 Infants, Toddlers & Fam. <input type="checkbox"/> 42 Independence Program (ACAP) <input type="checkbox"/> 77 Consolidated <input type="checkbox"/> 51 Adult Community Autism <input type="checkbox"/> 79 OBRA <input type="checkbox"/> 52 Autism Waiver <input type="checkbox"/> 80 0192 <input type="checkbox"/> 59 COMM CARE <input type="checkbox"/> 96 LIFE | For applicants - Check the appropriate HCBS program in which the individual was determined eligible or ineligible to receive services. For recipients - Check the appropriate HCBS program to indicate which HCBS program is affected by a change, transfer or termination of services. |
| <input type="checkbox"/> 16 MFP Participant Living in a Dom. Care Facility <input type="checkbox"/> 17 MFP Participant Living in Own Residence <input type="checkbox"/> 18 MFP Participant Living with a Family Member <input type="checkbox"/> 19 MFP Participant Living in Other Group Setting with Less Than Five People | For Money Follows the Person (MFP) applicants – Check the appropriate MFP code in which the individual was determined eligible or ineligible to receive services. For MFP recipients – Check the appropriate MFP code to indicate which MFP code is affected by a change, transfer or termination of services. In order to be eligible for MFP, an individual must be enrolled or enrolling in one of the following six HCBS programs: Aging Waiver, Attendant Care Waiver, Independence Waiver, COMM CARE Waiver, Consolidated Waiver, OBRA Waiver. |

**HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY / INELIGIBILITY / CHANGE FORM
INSTRUCTIONS FOR COMPLETION OF THE PA 1768**

| AGENCY INFORMATION | |
|-----------------------------------|--|
| ENROLLING AGENCY CONTACT PERSON | Enter the name of the person from the enrolling agency who may be contacted if information is needed by the CAO. This may be the person who conducted the level of care and functional assessment. |
| TELEPHONE NUMBER | Enter the contact person's telephone number. |
| ENROLLING AGENCY NAME AND ADDRESS | Enter the name of the agency and the agency's mailing address, including street, suite number, city, state and zip code. |
| FAX NUMBER | Enter the agency FAX number. This may be a dedicated FAX machine that the agency uses only for HCBS documents. |
| E-MAIL | Enter the contact person's e-mail address. |
| COMMENTS | Enter any comments that may be useful to the CAO. |
| ASSESSOR'S SIGNATURE | Enter the signature of the person who conducted the level of care and functional assessment. |
| TELEPHONE NUMBER | Enter the telephone number of the assessor. |

| INDIVIDUAL IDENTIFICATION INFORMATION | |
|---------------------------------------|---|
| NAME | Enter the individual's Last Name, First Name and Middle Initial. |
| MA RECORD NUMBER | Enter the individual's Medical Assistance record number including county code/ record number/ category. |

| CURRENT RESIDENT IN LTC FACILITY INFORMATION | |
|--|---|
| <input type="checkbox"/> INDIVIDUAL IS RESIDING IN LONG TERM CARE FACILITY | Check the box to indicate that the individual is residing in a LTC facility and is requesting HCBS upon discharge. |
| DATE OF DISCHARGE | Enter the date (month, day and year) that the individual will be discharged from the LTC facility. |
| LTC FACILITY NAME | Enter the name of the LTC facility where the individual resides. |
| ADDRESS | Enter the LTC facility's mailing address, including street, city, state and zip code. |
| <input type="checkbox"/> APPLYING FOR HCBS | Check the box to indicate the individual is requesting HCBS upon discharge from the LTC facility. |
| HCBS NAME: | Enter the name of the HCBS Program the individual is expecting to receive services from upon discharge from the LTC facility. |

| CURRENT ADMISSION TO A LTC FACILITY INFORMATION | |
|---|--|
| <input type="checkbox"/> INDIVIDUAL WAS ADMITTED TO LONG TERM CARE FACILITY OR PERSONAL CARE HOME / DOMICILIARY CARE FACILITY | Check the box to indicate that the individual was admitted to a LTC facility, Personal Care Home (PCH) or Domiciliary Care (DC) facility. |
| ADMISSION DATE | Enter the date that the individual was admitted. |
| <input type="checkbox"/> SHORT TERM ADMISSION (SERVICES EXPECTED TO RESUME AT DISCHARGE) | Check the box to indicate that the individual's admission to the LTC facility is for a short period of time and HCBS are expected to resume upon the individual's discharge from the facility. |
| LTC FACILITY OR PCH/DC FACILITY NAME | Enter the name of the LTC facility, PCH or DC facility. |
| ADDRESS | Enter the LTC, PCH or DC facility's mailing address, including street, city, state and zip code. |
| <input type="checkbox"/> AREA AGENCY ON AGING OFFICE NOTIFIED TO INITIATE PCH/DC APPLICATION (IF APPLICABLE) | Check the box to indicate that the Area Agency on Aging has been notified that the individual who was receiving HCBS has been admitted to a PCH or DC facility and an application may be needed. |

| INFORMATION REGARDING DEATH OF THE INDIVIDUAL | |
|---|---|
| <input type="checkbox"/> DECEASED | Check the box to indicate that the individual has died. |
| DATE OF DEATH | Enter the date (month, day and year) that the individual died. |
| CONTACT PERSON | Enter the name of an individual from the agency who may be contacted. |
| TELEPHONE NUMBER | Enter the telephone number of the contact person. |

**HOME AND COMMUNITY BASED SERVICES (HCBS) ELIGIBILITY / INELIGIBILITY / CHANGE FORM
INSTRUCTIONS FOR COMPLETION OF THE PA 1768**

| CHANGE OF ADDRESS INFORMATION - SAME COUNTY | |
|--|---|
| <input type="checkbox"/> INDIVIDUAL MOVED | Check the box to indicate that the individual has moved. |
| DATE OF MOVE | Enter the date (month, day and year) that the individual moved. |
| NEW ADDRESS | Enter the new address, including street, apartment number, city, state and zip code. |
| TELEPHONE NUMBER | Enter the individual's telephone number, including a message number (where a contact can be made to reach the recipient). |
| <input type="checkbox"/> SERVICES CONTINUED | Check the box to indicate that the individual continues to receive HCBS. |
| <input type="checkbox"/> SERVICES TERMINATED | Check the box to indicate that the individual's HCBS stopped. |
| DATE OF TERMINATION | Enter the month, day and year that the individual's HCBS stopped. |
| <input type="checkbox"/> VERIFICATION OF SHELTER EXPENSES ATTACHED FOR FOOD STAMPS | Check the box to indicate that the individual's new mortgage, rent, utility, and phone expenses have been verified and documentation is attached. |

| CHANGE OF COUNTY RESIDENCE INFORMATION | |
|---|--|
| <input type="checkbox"/> INDIVIDUAL MOVED TO _____ COUNTY | Check the box to indicate that the individual has moved to a new county. Enter the name of the new county of residence. |
| DATE OF MOVE | Enter the date (month, day and year) that the individual moved. |
| NEW ADDRESS | Enter the individual's new address, including street, apartment number, city, state and zip code. |
| TELEPHONE NUMBER | Enter the individual's telephone number including a message number (where a contact can be made to reach the recipient). |
| <input type="checkbox"/> SERVICES CONTINUED | Check the box to indicate that the individual continues to receive HCBS. |
| <input type="checkbox"/> SERVICES TERMINATED | Check the box to indicate that the individual's HCBS stopped. |
| DATE OF TERMINATION | Enter the month, day and year that the individual's HCBS stopped. |

| TRANSFERRING HCBS PROGRAM INFORMATION | |
|---------------------------------------|--|
| NAME OF HCBS TRANSFERRING FROM | Enter the name of the current HCBS providing services to the individual. Services under this HCBS program will end and be continued under another HCBS program. |
| SERVICES END DATE | Enter the last date (month, day and year) that the individual will be eligible for services. This is the last day that services will be provided under the present HCBS program. |
| NAME OF HCBS TRANSFERRING TO | Enter the name of the new HCBS that the individual will be enrolled in for continued services. |
| SERVICES BEGIN DATE | Enter the first date (month, day and year) that the individual will be eligible to receive services under the new HCBS program. |

| PROGRAM WITHDRAWAL INFORMATION | |
|--|---|
| <input type="checkbox"/> INDIVIDUAL VOLUNTARILY WITHDREW | Check the box to indicate that the individual requested that services not be authorized or that services be stopped. Enter the reason in the section labeled "OTHER INFORMATION." |
| DATE OF WITHDRAWAL | Enter the month, day and year that the individual requested a withdrawal. |

| TERMINATION OF HCBS PROGRAM INFORMATION | |
|---|---|
| <input type="checkbox"/> HCBS SERVICES TERMINATED | Check the box to indicate that the individual's HCBS stopped. |
| REASON | Enter the reason that the individual's HCBS were stopped. |
| DATE OF TERMINATION | Enter the month, day and year that the individual's HCBS stopped. |

| CHANGE IN INDIVIDUAL'S FINANCIAL STATUS | |
|---|--|
| <input type="checkbox"/> CHANGE IN THE INDIVIDUAL'S FINANCIAL STATUS DOCUMENTATION ATTACHED | Check the box to indicate that the individual's finances have changed and that documents are attached to verify the changes. |

| OTHER INFORMATION | |
|--|---|
| <input type="checkbox"/> OTHER (SPECIFY) | Check the box to indicate that additional information is being provided, including the reason(s) for non-participation in the HCBS Program. |

Appendix (C)(1)

OLTL Individual Service Plan

| OLTL INDIVIDUAL SERVICE PLAN | | | | | |
|--|------------|---------------------------|------------------------|--|--------|
| CONSUMER INFORMATION | | | | | |
| Name of Consumer (Last, First, Middle) | | | | | Date |
| Address (Street, Road, Avenue; City or Town, State) | | | | Zip Code | County |
| Telephone Number | Birth Date | Sex | Social Security Number | Recipient Number (MA ID) | |
| Race: | Email: | OLTL HCBS Waiver/Program: | | | |
| DIRECTIONS TO CONSUMER'S RESIDENCE | | | | | |
| | | | | | |
| INDIVIDUAL BACK-UP PLAN (support plan for unexpected disruption in service) | | | | | |
| Individual's Name/Agency Name | | | Telephone Number/Email | | |
| | | | | | |
| | | | | | |
| | | | | | |
| EMERGENCY BACK-UP PLAN (support plan in case of severe emergency) | | | | | |
| | | | | | |
| REPRESENTATIVE CONTACT(S)/Relationship | | | Telephone | | |
| | | | | | |
| | | | | | |
| | | | | | |
| PRIMARY LANGUAGE OR WAY OF COMMUNICATION | | | | | |
| | | | | | |
| Long Term Goals: | | | | | |
| | | | | | |
| Short Term Goals: | | | | | |
| | | | | | |
| Participant Strengths: (Including existing supports and resources) | | | | | |
| | | | | | |
| Household Composition (Name of Persons) | | | | Relationship to participant and age | |
| | | | | | |
| | | | | | |
| | | | | | |

From Distribution

1. Maintain original at SC Agency

2. Copy to participant and representative (if applicable)

Individual Service Plan
9/10

| List Identified Assessed Needs: | Met | Partially Met | How it is Met | Unmet |
|---------------------------------|-----|---------------|---------------|-------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Community Resources (Is the participant utilizing any community resources to assist with Independence):

List Informal Supports:

TPL (please list any other types of Insurance(s).)

If the participant is receiving any services that are not funded through OLTL waiver/program: Please list below

NON-WAIVER / PROGRAM SERVICES

| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | | Preferences |
|----------------------------------|---------------------|---------------------|----------------------------|--------------|------------|-----------------|-------------|
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |

| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | | Preferences |
|----------------------------------|---------------------|---------------------|----------------------------|--------------|------------|----------------|-------------|
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/Week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree | |

| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | | Preferences |
|----------------------------------|---------------------|---------------------|----------------------------|--------------|------------|-----------------|-------------|
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |

| OLTL WAIVER / PROGRAM SERVICES | | | | | | | |
|----------------------------------|---------------------|---------------------|----------------------------|-------|-----|---------------------------|-----|
| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | Preferences/Service Model | |
| | | | | | | | |
| Frequency/Duration (Hours/week) | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |
| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | Preferences/Service Model | |
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |
| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | Preferences/Service Model | |
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |
| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | Preferences/Service Model | |
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |
| Goal (Desired Outcome) | Identified Need | Action Step/Service | Provider/Responsible Party | | | Preferences/Service Model | |
| | | | | | | | |
| Frequency/Duration (Hours/Days): | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| Total Hours/week: | Any Barriers/Risks: | | Mitigation Strategy: | | | Agree/Disagree: | |

| | | | | |
|--|--|----------|--------|----------------------------------|
| HAVE YOU ADDRESSED ALL OF YOUR NEEDS AND RISKS IN THE SERVICE PLAN | | | | |
| Yes | | No | | If No, complete the next section |
| Unaddressed Needs/Risks/Barriers identified during the assessment process: | | | | |
| Mitigation Strategy (How are barriers being addressed/reduced?) | | | | |
| Additional Supports (Are additional supports needed?) | | | | |
| Discussion of mitigation strategies. Do you Agree/Disagree with the mitigation strategies? | | | | |
| Service Plan Type: | | Initial: | Annual | Revision |
| Date Completed | | | | |
| Your signature acknowledges that you received, reviewed and discussed the following information: | | | | |
| NOTIFICATION OF RIGHT TO APPEAL | | | | |
| PROVIDER CHOICE FORM | | | | |
| FREEDOM OF CHOICE FORM | | | | |
| TOLL FREE PARTICIPANT HELPLINE PHONE NUMBER | | | | |
| HOW TO REPORT INCIDENTS OF ABUSE, NEGLECT/EXPLOITATION | | | | |
| EMERGENCY BACK-UP PLAN (SEVERE WEATHER, ETC) | | | | |
| INDIVIDUALIZED BACK-UP PLAN | | | | |
| AVAILABLE SUPPORTS (BOTH WAIVER/PROGAM AND NON-WAIVER/PROGRAM) | | | | |
| MY INDIVIDUALIZED SERVICE PLAN | | | | |
| I HAVE BEEN INFORMED OF, UNDERSTAND AND ACCEPT THE RISKS IDENTIFIED IN MY SERVICE PLAN | | | | |
| Date: | Participant Signature: | | | |
| Date: | Representative Signature designated by participant: | | | |
| Date: | Signature of others who participated in developing the plan: | | | |
| Date: | Signature of others who participated in developing the plan: | | | |
| Date: | Service Coordinator Signature: | | | |
| Date: | Service Coordinator Supervisor Signature: | | | |

Appendix (C)(2)

New Participant Web Portal Referral CHECK LIST

NOTE: This form is to be utilized only when the PPL Web Portal is unavailable:

<https://fms2.publicpartnerships.com/PPLPortal/Login.aspx>



New Participant Web Portal Referral CHECK LIST

This reference document outlines key aspects of submitting a new participant referral through the PPL Web Portal. The Participant and Common Law Employer information listed below must be available when entering a new participant into Portal. Failure to populate the necessary Participant and Common Law Employer information may delay the enrollment process.

Section 1: Participant Demographic Profile

A. In the Participant Demographic Information Section please complete (at a minimum) the key areas below. If you are able to complete the additional demographic fields please do so.

- ✓ MA ID (Medicaid ID)
- ✓ First Name
- ✓ Last Name
- ✓ Both Physical & Mailing Addresses
- ✓ County
- ✓ Social Security Number
- ✓ Date of Birth
- ✓ Phone Number
- ✓ Enrollment Status:
- ✓ Diagnosis Code
 - The diagnosis code in Portal is configured to accept numbers only – this means that decimals must always be dropped. In addition, there are other instances of having to “massage” how these codes are documented to get portal to accept them (see below):
 - *Diagnosis codes regularly have a decimal place holder in them (example: 234.1, the problem with that is, the Portal field for diagnosis codes does not accept decimals for these codes. The solutions to this are just drop the decimal and list the numbers in a row - 2341.*
 - *Diagnosis codes vary in length - 3 to 6 numbers. There are instances where the diagnosis code is still incomplete after removing the decimal point and can be resolved by adding a zero(s) to the end of the last number.*
- ✓ Waiver Type

Important Note!

- If a data point has a * (red asterisk) next to it, it means it is required in order to save the profile. In other words, if you do not complete this data field and you submit the profile, you will lose all of your entries and the profile will not save.
- If a data question has OPTIONAL next to it, it means that this field is not necessarily needed in order to pay a timesheet for this participant’s DCW. However, many of these fields are important way that we contact the participant, so if you have the information please enter it.
- If a data question has *nothing* next to it, it means that is required in order to make the participant good to serve. If this data is missing the Participant will not be made good to serve.

- B. Once you have completed the required demographic information, please scroll down to the Common Law Employer section of the participant profile.

Section 2: Common Law Employer

- A. The Common Law Employer section is EXTREMELY important!
- ✓ This section must be completed even if the Participant is serving as their own Employer.
 - ✓ This section is used by PPL to pre-populate the Common Law Employer packet. This means that if information is missing, it will not pre-populate on the packet and it will cause a delay in the enrollment process.
- B. In the Common Law Employer section at a minimum the following data questions must be completed:
- ✓ CLE First Name
 - ✓ CLE Last Name
 - ✓ Address
 - ✓ City
 - ✓ State
 - ✓ Zip Code
 - ✓ SSN (Social Security Number)
- C. If the Participant is going to serve as the Employer, you may use the copy button to pull the physical address from the participant profile into the Common Law Employer profile.

Section 3: Designated Representative

- A. The Designated Representative section is for those individuals who are not serving as the legal employer but who plan to assist the participant in the management of their authorizations and direct care workers.
- ✓ As part of the Common Law Employer packet, the participant/employer is asked to identify if a designated representative exists. If the participant does not plan to use a designated representative this section may remain blank.
 - ✓ If a participant does plan to use a designated representative this section must be completed.

Section 4: Emergency Contact


- A. The Emergency Contact data fields are all optional fields. If the participant does not wish to provide us with an emergency contact they are not required to do so.
- ✓ Please be aware however, that PPL customer service will only provide information related to the Participant's account to the Participant, Employer, Designated Representative, Emergency Contact and assigned Service Coordinator.
 - ✓ If no Designated Representative or Emergency Contact are noted in the Web Portal the PPL customer service representative will not release the participant's information to the caller.

Appendix (C)(3)

New Participant F/EA FMS Interim Referral Form

NOTE: This form is to be utilized only when the PPL Web Portal is unavailable:

<https://fms2.publicpartnerships.com/PPLPortal/Login.aspx>

| | | | |
|---|---------------------------------|---|------------------------------|
|  | | New Participant F/EA FMS Interim Referral Form (Page 1 of 1) | |
| REFERRING AGENCY <input type="checkbox"/> NEW REFERRAL <input type="checkbox"/> TERMINATION | | | |
| Date: | Service Coordinator: | Phone: () | |
| Agency: | Service Coordinator Supervisor: | Alternate Phone: () | |
| Email address: | Fax #: () | | |
| Program: <input type="checkbox"/> OBRA Waiver <input type="checkbox"/> Attendant Care Waiver <input type="checkbox"/> Aging Waiver <input type="checkbox"/> Act 150 Waiver <input type="checkbox"/> CommCare Waiver <input type="checkbox"/> Independence Waiver | | | |
| NEW PARTICIPANT INFORMATION | | | |
| Last Name: | | First Name: | Medicaid ID #: |
| Address: | | | ICD-9 code: |
| City: | State: | Zip +4: | Email Address: |
| SS Number: | Date of Birth: | Gender: | Primary Language: |
| Phone: () | Alternate Phone: () | County of Residence: | |
| Note: We cannot accept referrals for any participant who has received FMS services or for whom Direct Care Workers were paid in 2012, until January 1, 2013. | | | |
| CONTACT INFORMATION, IF OTHER THAN PARTICIPANT | | | |
| Last Name: | | First Name: | Phone: () |
| Address if other than Participant: | | Relationship to participant: | Alternate Phone: |
| COMMON LAW EMPLOYER INFORMATION, IF OTHER THAN PARTICIPANT | | | |
| Last Name: | | First Name: | SS Number: |
| Address: | | | |
| City: | State: | Zip: | Relationship to participant: |
| Phone: () | Cell: () | Date of Birth: | Gender: |
| Alternate Phone: () | Email address: | | |
| Note: A participant can begin services when a HCSIS Service authorization is received and participant is notified by Public Partnerships that the 'Good To Go' Process is complete. | | | |
| Fax completed form to: 855-858-8158 or e-mail form to: padpw-oltl@pcgus.com. If you have any questions please call PPL Customer Service: 877-908-1750. | | | |
| NEW PARTICIPANT FMS INTERIM REFERRAL FORM (OLTL) | | | Page 1 |

Appendix (C)(4)

Freedom of Choice Form

**COMMONWEALTH OF PENNSYLVANIA
OFFICE OF LONG-TERM LIVING
Bureau of Participant Operations**

FREEDOM OF CHOICE FORM

Name (Last, First, Middle): _____

Address: _____

- I have been informed that I may be eligible for home and community-based services (HCBS).
- I know that enrollment in a home and community-based program is up to me.
- I have been informed what services I may be able to get and my rights and responsibilities under each service.
- Based on the information that has been presented to me, I want to [*check one*]:
 1. Receive HCBS such as Waiver or the LIFE Program where available.
 2. a Receive services in a nursing facility
b Receive services in an Intermediate Care Facility/Other Related Conditions (ICF/ORC)
 3. Receive no services

If I choose to receive HCBS, I know that I have the right to pick the agency that will provide each of my HCBS services from among the enrolled Medicaid HCBS providers in my area.

Form Distribution

- Maintain original at Enrolling Agency/AAA
- Copy to the consumer and representative (if applicable)
- Copy to selected Service Coordination Agency

Freedom of Choice Form
April, 2013

- I have been given my choice of Service Coordination agencies by the Enrolling Agency.
- I know that I may change my Service Coordination agency at any time.
- I know that the Service Coordination agency will review the list of available HCBS providers with me.

I have chosen the following agency as my Service Coordination agency:

 Service Coordination agency name

For all applicants to complete:

This form was thoroughly discussed with _____
 Participant/Representative

by _____ by means of _____.
 Service Coordinator/IEB/AAA (ex. Translator, American Sign Language, written, oral)

 Applicant/Representative's Signature Date

 Service Coordinator/IEB/AAA Signature Date

Form Distribution

- Maintain original at Enrolling Agency/AAA
- Copy to the consumer and representative (if applicable)
- Copy to selected Service Coordination Agency

Freedom of Choice Form
 April, 2013

Appendix (C)(5)

Service Provider Choice Form

**COMMONWEALTH OF PENNSYLVANIA
OFFICE OF LONG TERM LIVING
Bureau of Participant Operations
SERVICE PROVIDER CHOICE FORM**

Name (Last, First, Middle):

Address:

County:

Before you choose who will be providing your home and community-based services, we have to tell you that:

1. You have the right to decide who will give you the services listed in your Individual Service Plan as long as they are enrolled in the program and qualified to provide you those kinds of services.
2. You have the right to talk to or interview someone from any provider before making your choice of providers. Interviewing providers can be a long process and might result in a delay of services.
3. You will not be forced to choose a particular provider.
4. You can decide on a different provider for each different service.
5. You may choose more than one service provider to give you the same kind of service as needed.
6. You can self-direct your home and community-based services if the particular Waiver program in which you are enrolled permits this model.
7. You can change your mind about who gives you services at any time by telling your Service Coordinator
8. If there are issues you have been unable to resolve or it would be hard discussing them with your Service Coordinator, you may call the OLTL Quality Assurance Helpline at 1-800-757-5042. There is no charge for calling this number.

Form Distribution

- Maintain original at Service Coordination Agency
- Copy to the consumer and representative (if applicable)

Provider Choice Form

April 2013

Page 74 of 4 pages

Please acknowledge the following statements by checking each box and signing at the bottom of the form:

- I understand my rights to choose my provider(s) and my responsibilities in making those choices.
- My Service Coordinator has given me a list of service providers who could possibly provide each service listed in my Individual Service Plan from the Service and Supports Directory (SSD) located at:
<https://www.humanservices.state.pa.us/compass/EPPProviderSearch/Pgm?EPWEL.aspx?prg=LTH>.
- I understand that I may talk to someone from any services provider before making my decision in selecting a provider.
- I have freely chosen the provider for each service listed in my Individual Service Plan on the back of this form.
- I understand that I can:
 - Choose to self-direct some of my services if the waiver in which I am enrolled permits this model; or
 - Choose not to self-direct any, all or some of my services
- I have made these choices without being pressured or forced.
- I have been involved in developing my Individual Service Plan.
- I understand if I have concerns or complaints about my services that I should contact my Service Coordinator.

Participant's Signature

Date

Representative's Signature (as appropriate)

Date

Service Coordinator Signature

Date

Form Distribution

- Maintain original at Service Coordination Agency
- Copy to the consumer and representative (if applicable)

Provider Choice Form

April 2013

Page 2 of 4 pages

If you have someone who is helping you or supporting with this discussion, please ask that person to sign to show that they have taken part by helping you.

Signature

Date

Form Distribution

- Maintain original at Service Coordination Agency
- Copy to the consumer and representative (if applicable)

Provider Choice Form

April 2013

Page 3 of 4 pages

Appendix (C)(6)

OLTL Service Authorization Form (MA 560)



OLTL Service Authorization Form HCBS Waiver Programs

| | | | | | | |
|---|--|--|---------------------------------------|---|--|--------------------------------------|
| DATE: | | <input type="checkbox"/> Annual Renewal | <input type="checkbox"/> New referral | <input type="checkbox"/> Temporary change | <input type="checkbox"/> Revision (change in need) | <input type="checkbox"/> Termination |
| CONSUMER'S NAME: | | | | | DOB: | |
| ADDRESS: | | | | | PHONE/EMAIL: | |
| PRIMARY CONTACT (RELATIONSHIP TO CONSUMER): | | | | | PHONE/EMAIL: | |
| PRIMARY CARE PHYSICIAN | | | | PHONE/FAX/EMAIL: | | |
| ICD-9 DIAGNOSIS CODE: | | | | MEDICAL ASSISTANCE NUMBER (10 DIGITS): | | |
| PROVIDER NAME: | | | | | | |
| PROGRAM NAME: | | | | | | |
| <input type="checkbox"/> OBRA Waiver | | <input type="checkbox"/> Independence Waiver | | <input type="checkbox"/> CommCare Waiver | | |
| <input type="checkbox"/> Attendant Care/Act 150 | | <input type="checkbox"/> Aging Waiver | | <input type="checkbox"/> AIDS Waiver | | |

SERVICE AUTHORIZED (TYPE):

| | | |
|---|---|--|
| <input type="checkbox"/> Accessibility adaptations | <input type="checkbox"/> Home health nursing (LPN)** | <input type="checkbox"/> Personal assistance services (CSLA)* |
| <input type="checkbox"/> Adult daily living | <input type="checkbox"/> Home health nursing (RN)** | <input type="checkbox"/> Personal emergency response system (PERS) |
| <input type="checkbox"/> Behavior therapy | <input type="checkbox"/> Home health occupational therapy** | <input type="checkbox"/> Prevocational services* |
| <input type="checkbox"/> Cognitive rehabilitation* | <input type="checkbox"/> Home health occupational therapy-assist.** | <input type="checkbox"/> Residential habilitation |
| <input type="checkbox"/> Community integration* | <input type="checkbox"/> Home health physical therapy** | <input type="checkbox"/> Respite (agency)* |
| <input type="checkbox"/> Community transition services | <input type="checkbox"/> Home health physical therapy-assist.** | <input type="checkbox"/> Service coordination |
| <input type="checkbox"/> Counseling services | <input type="checkbox"/> Home health speech and language therapy** | <input type="checkbox"/> Structured day habilitation |
| <input type="checkbox"/> Durable medical equipment & supplies | <input type="checkbox"/> Non-medical transportation | <input type="checkbox"/> Supported employment* |
| <input type="checkbox"/> Home delivered meals | <input type="checkbox"/> Nutritional counseling | <input type="checkbox"/> Transition service coordination |
| <input type="checkbox"/> Home health aide* | <input type="checkbox"/> Personal assistance services (agency)* | <input type="checkbox"/> Telecare |

* (Details of activities for these services are listed below.)
 ** (Must be accompanied by a script renewed every 60 days.)
 *** For all participant-directed and Financial Management Services (FMS), please use the referral protocols established by the Vendor Fiscal/Employer Agent (VF/EA).

| | | | |
|--|--|---|-----------------|
| TOTAL NUMBER OF APPROVED UNITS PER WEEK (AMOUNT): | | SERVICE PROVISION DATES (SERVICE BEGIN AND END DATES/APPLICABLE DATES): | |
| PREFERRED SCHEDULE (DURATION AND FREQUENCY): | | | |
| DESIRED OUTCOME OF SERVICE: | | | |
| SERVICE COORDINATOR (SC): | | SC AGENCY: | SC PHONE/EMAIL: |
| SPECIAL CONDITIONS/INSTRUCTIONS: | | | |
| INDIVIDUALIZED BACKUP PLAN: | | | |
| UNIQUE CIRCUMSTANCES (ALLERGIES, SMOKING/PETS, CHILDREN UNDER 18, ETC.): | | | |



| | |
|--|---------------------------------|
| *DETAILS OF CURRENT NEEDS: THE CONSUMER WILL NEED ASSISTANCE WITH THE FOLLOWING ADL/IADLS (SCOPE): | |
| <input type="checkbox"/> | Bathing |
| <input type="checkbox"/> | Hair care |
| <input type="checkbox"/> | Dressing |
| <input type="checkbox"/> | Lotion/ointment |
| <input type="checkbox"/> | Meal preparation |
| <input type="checkbox"/> | Eating/drinking |
| <input type="checkbox"/> | Laundry |
| <input type="checkbox"/> | Light housekeeping |
| <input type="checkbox"/> | Shopping |
| <input type="checkbox"/> | Medication management |
| <input type="checkbox"/> | Reading/writing |
| <input type="checkbox"/> | Managing finances |
| <input type="checkbox"/> | Social/leisure activities |
| <input type="checkbox"/> | Telephone/communication devices |
| <input type="checkbox"/> | Securing transportation |
| <input type="checkbox"/> | Appointment scheduling |
| <input type="checkbox"/> | Caring for personal possessions |
| <input type="checkbox"/> | Obtaining seasonal clothing |
| <input type="checkbox"/> | Using a prosthetic device |
| <input type="checkbox"/> | Ambulating |
| <input type="checkbox"/> | Range of motion |
| <input type="checkbox"/> | Supervised walks |
| <input type="checkbox"/> | Supervision/coaching/cueing |
| <input type="checkbox"/> | Toileting |
| <input type="checkbox"/> | Bowel/bladder management |
| <input type="checkbox"/> | Transfers |
| <input type="checkbox"/> | Incontinence care |
| <input type="checkbox"/> | Catheter care |
| <input type="checkbox"/> | Wound care |
| <input type="checkbox"/> | G-tube feedings |
| <input type="checkbox"/> | Other |

MA 560 12/13

Appendix (C)(7)

Notice of Service Determination and the Right to Appeal (MA 561)



Notice of Service Determination and the Right to Appeal

Date this notice was mailed or hand-delivered to you:

SECTION I - PARTICIPANT INFORMATION

Participant Name:

Participant Address:

SECTION II - SERVICE DETERMINATION

On _____ (insert date) the _____ (insert SC agency) made the following service delivery determination:

Program:

You are currently eligible and enrolled in the program checked below:

- Aging Waiver (810) AIDS Waiver (940) Attendant Care Waiver (860) COMMCARE Waiver (864)
 Independence Waiver (861) OBRA Waiver (861) Act 150

Service Determination:

Your service delivery determination:

- Denial of: (identify specific service(s) being denied) _____
 Reduction of: (identify service(s) being reduced and the effective date) _____
 Termination of: (identify service(s) terminated and the effective date) _____
 Suspension of: (identify specific service(s) suspended and the effective date) _____
 Act 150 fee computation: _____

Reason for Service Determination:

This decision has been made based on the following reason(s), including any departmental policy and/or regulation:

Questions and Concerns:

If you have any questions or concerns regarding this notice, please contact:

Service coordinator:

Telephone number:

SECTION III - APPEAL RIGHTS AND INSTRUCTIONS

- You have the right to appeal if you are dissatisfied with any decision to deny, reduce, terminate or suspend service provided to you under the Medicaid Waiver or Home and Community-Based Services program.
- You have the right to appeal if you are denied the willing and enrolled provider of your choice.
- You have the right to appeal the computation of the fee amount for Act 150 services, but not the fee itself.
- You will **not** be granted a hearing if the action taken was solely by state or federal law or regulation requiring a change in the type of services available under the waiver program.

Representation:

You have the right to represent yourself or to have someone else represent you. A staff member of the _____ (insert SC agency)
(NAME OF SC AGENCY) will refer you to agencies that may be able to provide legal help if you so request. During the appeal process, you or your representative can present the reasons why you think the proposed action is incorrect and present evidence and/or witnesses to support your case.

You may consult with family members and/or an attorney for assistance in determining whether to appeal. For some participants, the long-term care ombudsman may serve as a point of contact in providing you with information and assistance regarding your rights and the fair hearings and appeals process.

You or your representative has the right to examine all information that will be introduced at the hearing, as well as other information in your case file that is not exempt under 55 Pa. Code § 105.5(b). There may be a charge for copies of these documents.

How to Appeal:

If you decide to appeal, you must submit your request to _____ (insert SC agency)
(NAME OF SC AGENCY) within 30 calendar days of the date of this notice.

Your request must be postmarked on or before _____ (insert date)
DATE which is 30 calendar days following the date of this notice.

**If you are currently receiving services and your appeal request is postmarked or received by _____ (insert date)
DATE (which is within 10 calendar days of the date of this notice), you will continue to receive services at the current level pending the outcome of the hearing. However, if your appeal is postmarked after this date, your services will change as shown in Section II.**

Your appeal must be in writing as follows:

Fill out Section IV and sign Section V of this form; keep a copy for your records.

- Give the reason for your appeal **and**
- Give your telephone number **and**
- Give your exact address **and**

Mail or take all pages of this form to the agency at the following address:

Insert Agency Address In This Space

SECTION IV - REQUEST TO APPEAL

Reason for Appeal:

What is the reason(s) for your appeal? Please specify:

(You may attach additional supporting documentation or information. Use additional paper if necessary.)

Resolution Being Sought:

What outcome would you like? Please specify:

(Use additional paper if necessary.)

Type of Hearing:

The Bureau of Hearings and Appeals at the Department of Public Welfare will hold a hearing for you either over the telephone or face-to-face. You may choose which type of hearing you want. If you do not have a telephone in your home and cannot get to one (for example, a friend or relative's telephone), you may go to the telephone hearing at your local agency or at a site approved by the local agency. If you wish to have a face-to-face hearing, you must make such a request when you file your appeal. A face-to-face hearing will be scheduled for you at the closest available location. Transportation cost for a face-to-face hearing is the responsibility of the participant.

Type of Hearing (check one): Telephone hearing Face-to-face hearing

If you request a face-to-face hearing and you require reasonable accommodations, please describe:

(Use additional paper if necessary.)

Interpreter Services:

If you speak a language other than English or need an alternative form of communication or if you need an interpreter, you may request help in obtaining an interpreter. You must make that request in advance of the hearing. There will be no cost to you for this service.

Check if you need an interpreter: What language? _____

Check if you need an alternative form of communication: If so, please specify: _____

SECTION V - SIGNATURES

This section is to be completed by the participant or the participant's representative. Sign this form only if you disagree with the services and want to appeal.

Participant:

| | | |
|---------------------|-----------------------|------------------|
| _____ | _____ | _____ |
| Date | Participant Signature | Telephone Number |
| _____ | | |
| Participant Address | | |

Participant's Representative (if applicable):

| | | |
|-----------------------------|--------------------------|------------------|
| _____ | _____ | _____ |
| Date | Representative Signature | Telephone Number |
| _____ | | |
| Representative Address | | |
| _____ | | |
| Relationship to participant | | |

SECTION VI - AGENCY USE ONLY

Form Distribution:

Upon receipt of appeal request from participant, service coordination agencies must, within three working days, mail a hard copy of this completed form and a hard copy of the completed Bureau of Hearings and Appeals agency cover sheet to the Bureau of Hearings and Appeals regional office, based on the participant's county of residence.

Additionally, you must email a copy of this form to the Office of Long-Term Living within three working days at: ra-oltlapeals@pa.gov.

Appendix (C)(8)

Bureau of Hearings and Appeals (BHA) Agency Appeal Cover Sheet

NON-CAO Cover Sheet 10/12

BUREAU OF HEARINGS & APPEALS AGENCY APPEAL COVER SHEET

PART I – CASE RECORD INFORMATION - BHA USE ONLY

ACCESS ID # BHA Use Only

| | | |
|----------|---|------------|
| County # | Welfare Case Record Number or Pseudo Number | Appeal No. |
|----------|---|------------|

PART II – AGENCY INFORMATION - TO BE COMPLETED BY THE AGENCY

| | | | | |
|------------------------------------|-------|----------|-------|----|
| Agency | | | | |
| Agency Contact Person Name | | Last | First | MI |
| Agency Contact Person Title | | | | |
| Agency Address | | | | |
| City | State | Zip Code | - | |
| Agency Contact Telephone No. () - | | | | |

PART III – APPELLANT INFORMATION - TO BE COMPLETED BY THE AGENCY

| | | | | |
|-------------------------------|--------------------------|----------|-------|----|
| Appellant Name | | Last | First | MI |
| Sex | Facility (if applicable) | | | |
| Address | | | | |
| City | State | Zip Code | - | |
| Appellant Telephone No. () - | | | | |

PART IV – APPELLANT’S REPRESENTATIVE INFORMATION - TO BE COMPLETED BY THE AGENCY

| | | | | |
|--|-------|---------------------------|-------|----|
| Representative’s Name | | Last | First | MI |
| Representative’s Agency (if applicable) | | | | |
| Representative’s Address | | | | |
| City | State | Zip Code | - | |
| Representative’s Telephone No. () - | | Relationship to Appellant | | |
| 2nd Representative’s Name | | Last | First | MI |
| 2nd Representative’s Agency (if applicable) | | | | |
| 2nd Representative’s Address | | | | |
| City | State | Zip Code | - | |
| 2 nd Representative’s Telephone No. () - | | Relationship to Appellant | | |

PART V – APPEAL INFORMATION - TO BE COMPLETED BY THE AGENCY

| # | Issue | Category | Continue Benefits? | Adverse Action Notice (form #, letter etc) | Adverse Action Notice Date |
|---|-------|---------------------|--------------------|--|----------------------------|
| #1 | | | | | |
| #2 | | | | | |
| #3 | | | | | |
| Date Filed | | Interim Relief Date | | Hearing Type (T, F or N) | IR Case? (Y or N) N |
| Special Scheduling Requests or Accommodations | | | | | |
| Comments | | | | | |

PART VI - LIMITED ENGLISH PROFICIENCY (LEP) ASSESSMENT – TO BE COMPLETED BY THE AGENCY (required)

| | | | | |
|--|--|--|----------------------------------|------------------------------------|
| Language Code | Language | Name of Agency Staff Making Assessment | | Telephone No. of Above Staff () - |
| Translated documents? <input type="checkbox"/> Yes <input type="checkbox"/> No | Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| TO BE COMPLETED BY BHA: LEP ASSESSMENT BY: (enter initials) | PERFECTOR: DATE: _____ | SITE ADMIN/DESIGNEE: DATE: _____ | HEARING OFFICIAL: DATE: _____ | LEGAL ASSISTANT: DATE: _____ |
| | INTERPRETER: TRANSLATION OF DOCUMENTS: LANGUAGE: | NO / YES NO / YES | NO / YES NO / YES | NO / YES NO / YES |

PART VII – BHA USE ONLY

| | | | | | |
|--------------------------|--------------|--------------|----------------|------------------------|------|
| Administrative Law Judge | Hearing Date | Hearing Time | Hearing Length | Perfectd by (initials) | Date |
| CC: | | | | | |

Appendix (C)(9)

Decision to Withdraw an Appeal Request (MA 562)



Decision to Withdraw an Appeal Request

| SECTION I - PARTICIPANT INFORMATION | |
|--|---|
| Participant name: | |
| Address: | |
| SECTION II - WITHDRAWAL | |
| I want to withdraw my request to appeal. I understand that this means that I will not have a hearing to decide my case, or if I have already had a hearing, that I will not receive a decision from the hearing officer. | |
| _____ | _____ |
| Date | Participant signature |
| _____ | _____ |
| Date | Participant's representative (if applicable) |
| SECTION III - AGENCY USE ONLY | |
| Form distribution: | |
| Upon receipt of the withdrawal request from the participant, the service coordination agency will date stamp the form, immediately notify the Bureau of Hearings and Appeals regional office, and send a copy of this completed form to the following: | |
| Mail hard copy to: | Department of Public Welfare Bureau of Hearings and Appeals Regional Office |
| Send an email copy to the Office of Long-Term Living at: | ra-oltlappeals@pa.gov |

Appendix (C)(10)

PROMISE Provider Enrollment Base Application CHECK LIST

- _____ PROMISE Provider Enrollment Base Application (must contain original signatures)
- _____ Outpatient Provider Agreement (must contain original signatures)
- _____ Ownership or Control Interest Pages
- _____ Legal Entity Verification Document (*IRS-generated form with FEIN, business name, and address*)
- _____ Articles of Incorporation (if applicable)
- _____ Partnership Agreement (if applicable)
- _____ Copy of Pennsylvania Department of Health Home Care License (if applicable)
- _____ Copy of Pennsylvania Department of Aging Adult Day Care License (if applicable)
- _____ Copy of Pennsylvania State Certification(s) or license (if applicable)
- _____ Most Recent Tax Return, as applicable
- _____ Most Recent Monthly Balance Sheet or Business Plan
- _____ Most Recent Audit or Financial Review (if applicable)
- _____ Provider Enrollment Information Form: Aging - CommCare/Independence/OBRA - ACW/150
- _____ Qualifications of the Executive Director and/or the Program Director (Include copies of their diplomas and resume)
- _____ OLTL-HCBS Waiver Agreement

Proof of Insurances

- _____ General Liability
- _____ Worker's Compensation
- _____ Professional Liability (if app.)

Policy Compliances

- | | |
|------------------------------------|---|
| _____ ADA Compliance Policy | _____ Criminal History Background Check Policy |
| _____ HIPPA Compliance Policy | _____ Critical Incident Management Policy |
| _____ Non-discrimination Policy | _____ Employee Screening for Exclusion Policy (LEIE, EPLS & Medichex) |
| _____ Quality Management Policy | _____ Employee SSN Verification Policy |
| _____ Regulation Compliance Policy | _____ Limited English Proficiency (LEP) Policy |
| _____ Staff Training Policy | _____ Participant Complaint Management Policy |

Please Note: OLTL must receive all documents in the checklist in order to process your enrollment application. The enrollment process may take several weeks to complete.

If you should have any questions, please contact the Provider Support Call Center at 1-800-932-0939 or send an email to RA-HCBSEnProv@pa.gov .

Please return all completed documents including the checklist to:

**Office of Long-Term Living
Bureau of Quality and Provider Management
Certification and Enrollment Section
555 Walnut Street, 6th Floor
P.O. BOX 8025
Harrisburg PA 17106-8025**

Appendix (C)(11)

PROMISe Provider Enrollment Base Application

INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

Applications must be typed or completed in black ink, or they will not be accepted.
Applications will be scanned - please do NOT staple.

Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.

1. Enter the complete name of the individual or facility.
- 2a. Check the appropriate boxes for the action(s) you request.
- 2b. If you are reactivating a provider number, indicate the PROMISe™ 13 digit provider number you wish to have reactivated and complete the application as an initial enrollment.
- 2c. If this is a name change, indicate the old name and the new name. **To verify your updated name, a copy of a document generated by the Federal IRS listing your name and SSN or FEIN must accompany your application. (i.e. SSN, W-2 or tax label).**
- 2d. If you are adding a provider to an existing group, enter the PROMISe™ 13 digit group provider number. The 4-digit service location code must correspond with a valid active street address. **We will not assign fees to a service location listed as a P.O. Box.**
•Fee assignments may only be made between "like provider types". Call the Enrollment Hotline for verification at 1-800-537-8862.
3. Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes. Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the healthcare provider applying for enrollment. Refer to:

<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/nationalprovideridentifiernpiinformation>
4. Enter the requested effective date for your action request.
5. Enter your provider type number and description (e.g., provider type 31, Physician).
6. Enter your specialty name and code number. **See the requirements for your provider type.**
7. Enter your sub-specialty name(s) and code number(s), if applicable. **See the requirements for your provider type.**
8. Enter your Social Security Number. **A copy of your Social Security card, W-2, or document generated by the Federal IRS containing your Social Security Number must accompany your application. If completing #8, do not complete #9. Refer to the checklist for additional requirements.**
9. Enter your Tax Identification Number (TIN). **A copy of the TIN label or document generated by the Federal IRS containing the name and IRS number of the entity applying for enrollment must accompany this application. A W-9 form will not be accepted. If completing #9, do not complete #8.**
10. Enter your legal name as it is filed with the IRS and as it appears on IRS generated documents..

12/2/11

1

- 11a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).
- 11b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.
- 12a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.
- 12b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/stamped fictitious business name statement/permit.**
13. Enter your date of birth.
14. Enter your gender.
15. Enter the title/degree you currently hold.
- 16a. Enter your IRS address. This address is where your 1099 tax documents will be sent.
- 16b-f. Enter the contact information for the IRS address.
17. Check the appropriate box for the business type of the individual or facility applying for enrollment. Check 1 box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
18. Enter your license number (if applicable), issuing state, issue date, and expiration date.
***A copy of your license must be included with the application.**
19. Enter your Drug Enforcement Agency (DEA) Number (if applicable).
*** A copy of your DEA certificate must be included with the application.**
20. Enter your CMS number.
***A copy of your CMS certification must be included with the application.**
- 21a. Enter a valid service location address. **The address must be a physical location, not a post office box. The zip code must contain 9 digits and the phone number must be for the service location. Refer to block #25 of the application to list an additional address (es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 21a.**
- NOTE* you can sign up for the **Electronic Funds Transfer Direct Deposit Option** by following the link below:
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm>
- 21b-c. Answer question, if yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins or RA's please call the phone number listed.
- 21d. If you wish Medicare claims to crossover to this service location check this box. **Note: This crossover can be added to only one service location.**
- 21e-h. Enter contact information.
- 21i. Indicate whether you or your staff is able to communicate with patients in any language other than English.
- 21j. If applicable, list the additional languages in which you or your staff can communicate.

12/2/11

2

- 21k. Answer questions 1 through 4 pertaining to the Americans with Disabilities Act (ADA).
- 21l. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **Refer to the PEP Descriptions and the requirements for your provider type.**
22. Indicate whether you retain any managing employees or agents.
*IF "yes" complete Attachment I found here:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf
- 23a-e. The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions, A through E.
If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application. (Refer to the Confidential Information sheet).
- 23f. Include responses to 23F, 1 to 14, if you answered YES to any of the questions in 23A-E.
24. Sign the application and print your name, title, and date **(The signature should be that of the individual applying for enrollment or someone able to represent the facility applying for enrollment). Use black ink.**
25. This page, beginning with block #25, may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in 21a. **This sheet cannot be used to add a service location.**
- 25a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.
- 25b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.
- 25c. Enter the e-mail address of the contact person for this address.
- 25d-g. Enter the contact information for this address.
- Use page 13 to add additional service locations upon **the INITIAL ENROLLMENT OF AN INDIVIDUAL.**
 - **Facilities must complete a new base application to add additional service locations to their file.**
 - **The individual applying for enrollment or a representative of the facility applying for enrollment must complete the Provider Agreement included with the application.**

When completed, review the "Did You Remember..." Checklist included with the application.

Return your application and other documentation to the address listed on the requirements for your specific provider type.

If no address is listed on the requirements for your specific provider type/specialty, please mail to:

**DPW Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045**

12/2/11

3

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program (PEP) code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to consumers of that program. Providers should use the following PEP codes when enrolling in PROMISe™ and should use the descriptions in this document to determine which PEP code to use when enrolling in PROMISe™.

Adult Autism Waiver – Contact Number: (866) 539-7689; Email: ra-odpautismwaiver@pa.gov ;
Website: <http://www.dpw.state.pa.us/foradults/autismservices/adultautismwaiver/index.htm>

The AAW is designed to help adults with an autism spectrum disorder participate in their communities in the way that they want to, based on their individual needs. It is a statewide home and community-based waiver. To become an AAW provider, contact the Bureau of Autism Services and an enrollment representative will reply by phone or by sending an electronic "Provider Packet." The packet includes necessary links, information and instructions on how to become an enrolled provider.

Aging Waiver – Contact Number: (717) 772-2570 or (800) 932-0939

Providers should enroll in the Aging Waiver if they would like to provide home- and community-based services to Nursing Facility Clinically Eligible (NFCE) individuals age 60 or over. Services provided in this PEP are personal care, respite, transportation, adult day care, durable medical equipment (DME) and supplies, environmental modifications, home health care, home delivered meals, personal emergency response services, counseling, and personal assistance services (attendant care).

AIDS Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Providers may enroll in the AIDS waiver to provide home- and community-based services to individuals 21 and older with AIDS or Symptomatic HIV Disease. Services provided are Home Health care, Homemaker, Nutritional Consultation and Supplements and Specialized Medical Equipment and Supplies. Providers in non-mandatory Managed Care Counties must be approved by the Waiver Enrollment Unit of the Bureau of Provider Support in the Office of Long Term Living. Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

Attendant Care Waiver/ Act 150 Program - Contact Number: (717) 772-2570 or (800) 932-0939

A Home and community based program developed for mentally-alert Pennsylvanians with physical disabilities. Services provided through the Attendant Care Waiver include:

- Attendant Care (Agency and Consumer Model), such as:
 - Assisting a person to get in and out of bed, wheelchair and/or motor vehicles
 - Assisting a person to perform routine bodily functions
 - Assistance with cognitive tasks including managing finances, planning activities, and making decisions
 - Companion-type services, including assistance with transportation, letter writing, reading mail, and escort
 - Financial Management Services
 - Homemaker type services, such as shopping, laundry, cleaning, and seasonal chores
- Personal Emergency Response System (Installation and Maintenance)
- Service Coordination

Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

BHHC – Contact Number: (800) 433-4459

Assignment of BH HC reflects an enrollment in PROMISe to serve in-plan supplemental HealthChoices clients. This PEP is not considered an entitlement for funding from any MHMR Program, nor a guarantee of a definitive number of referrals.

12/2/11

4

COMMCARE Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Home and community based program developed for individuals who experience a medically determinable diagnosis of traumatic brain injury (TBI). Services provided through the COMMCARE Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Community Integration
- Educational Services
- Financial Management Services
- Habilitation and Support
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistance Services
- Personal Emergency Response System (Installation and Maintenance)
- Prevocational Services
- Respite (Consumer or Agency Model)
- Service Coordination
- Structured Day Program
- Supported Employment
- Therapeutic & Counseling Services
- Transportation

Consolidated Waiver – (888) 565-9435

Home and Community-Based program developed for Pennsylvania residents age 3 and older with a medically determined diagnosis of mental retardation. The Consolidated Waiver is designed to provide services to eligible persons with mental retardation so that they can remain in the community

Fee-for-Service (FFS) - Contact Number: (800) 537-8862 – Option 1

A comprehensive set of Medical Assistance services which include reimbursement for direct inpatient and outpatient, physical health, and behavioral health services to consumers through components of the Medical Assistance Program. If you are trying to provide services under the Managed Care and/or FFS programs, you should select the FFS PEP.

If you are requesting enrollment to be a provider of a HealthChoices Supplemental Service(s) for Behavioral Health, contact the BH-MCO with which you will be doing business as this application is not applicable.

Healthy Beginnings Plus (HBP) - Contact Number: (717) 772-6127

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance, to have a positive prenatal care experience. HBP expands the scope of maternity services that can be reimbursed by the Medical Assistance Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the HBP program. Services covered by HBP include childbirth and parenting classes, nutritional and psychosocial counseling, smoking cessation counseling, home health services and other individualized client services. Please note: A separate HBP enrollment application must be completed to add this program to your eligibility.

Independence Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

The Independence waiver provides services to persons with physical disabilities to allow them to live in the community and remain as independent as possible. Services provided through the Independence Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Adult Daily Living
- Community Integration
- Educational Services
- Financial Management Services
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistant Services
- Personal Emergency Response System (Installation and Maintenance)
- Respite Care
- Service Coordination
- Therapeutic & Counseling Services
- Transportation Services

Living Independently for Elders (LIFE) – Contact Number: (717) 772-2570 or (800) 932-0939

Providers should enroll as a provider under the Long Living Independently for Elders (LIFE) if they plan to provide long-term care services to Nursing Facility Clinically Eligible (NFCE) individuals age 55 or over. All providers in this PEP must be approved by the Division of LTC Client Services and have an existing agreement with the Department to provide services under the national Program of All-inclusive Care for the Elderly (PACE) model under either federal PACE provider Status or under Prepaid Health Plan Authority. The goal is to maintain individuals in the community, but services are also provided in institutional settings when appropriate. Providers manage and provide an all-inclusive package of services to enrolled recipients and are reimbursed a monthly capitation payment for services provided.

Mental Retardation Base Program (MR Base Program) - Contact Number: (888) 565-9435

The MR Base Program is a program that is designed for Pennsylvania residents of any age who have a medically determined diagnosis of mental retardation.

OBRA Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Services provided through the OBRA Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Adult Daily Living
- Community Integration
- Educational Services
- Financial Management Services
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistant Services
- Personal Emergency Response System (Installation and Maintenance)
- Prevocational Services
- Respite Care
- Service Coordination
- Supported Employment Services
- Therapeutic & Counseling Services
- Transportation Services

Person/family Directed Support Waiver (Per/Family Services) – Contact Number: (888) -565-9435

The Person/Family Directed Support Waiver is a Home and Community-Based waiver program that is designed for Pennsylvania residents age 3 and older with a medically determined diagnosis of Mental Retardation. This waiver is designed to prevent the institutionalization of individuals with mental retardation who do not require Office of Developmental Programs licensed community residential services and allows these individuals to remain in the community.

ATTENTION OMR PROVIDERS: Fax completed application to ODP @ 717-783-5141 or mail to: Office of Mental Retardation Room 413 Health and Welfare Building Harrisburg, PA 17101 Attn: Provider Enrollment

PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of Enrollee:

Facility:

or

Last Name: _____ First: _____ MI: _____

2. Action Request: Check Boxes that Apply:

a. Initial Enrollment: Individual Facility

b. Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): _____ (13 digits)

(Complete the application as an initial enrollment.)

c. Name Change: (Name change only. Must match IRS generated documentation.)

Old Name: _____

New Name: _____

d. Fee Assignment – Add this provider to existing provider group. Specify group provider number:

_____ (Must be a 13 digit number to be processed).

3. National Provider Identifier Number: _____ (10 digits)

Taxonomy(s): _____ (10 digits) _____ (10 digits)

Taxonomy(s): _____ (10 digits) _____ (10 digits)

4. Requested Effective Date:

yyyy / mm / dd – (2004/07/31)

____/____/____

5. Provider Type Number and Description:

Number: _____ (2 digits)

Description: _____

6. Specialty(s) and Code(s), if applicable:

Specialty: _____

Code Number: _____ (3 digits)

7. Sub-Specialty(s) and Code(s), if applicable:

Sub-Specialty(s): _____

Code Number(s): _____ / _____ (3 digits)

8. Social Security Number: _____ - _____ - _____

*** A copy of a document generated by the Federal IRS with your name and SSN must accompany this application.**

9. Federal Tax ID Number: (If #8 is completed, DO NOT complete this item.)

_____ (9 digits)

***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application.**

10. Legal Name Shown on Attached Document:

12/2/11

7

| | | |
|---|--|---|
| <p>11a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>11b. If so, list the MCO(s):</p> <p>_____</p> <p>_____</p> | |
| <p>12a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>12b. If yes, list the Statement/Permit number and the name:</p> <p>Number: _____</p> <p>Name: _____</p> <p>*A legible copy of the recorded/stamped fictitious business name statement/permit is required for your application to be processed.</p> | |
| <p>13. Date of Birth: yyyy / mm / dd (2004/07/31)</p> <p>____ / ____ / ____</p> | <p>14. Gender:</p> <p>Male Female</p> <p><input type="checkbox"/> <input type="checkbox"/></p> | <p>15. Title/Degree as it appears on license:</p> |
| <p>16a. IRS Address: Note: This is the address where your 1099 tax document will be sent.</p> <p>Street: _____ Room/Suite: _____</p> <p>City: _____ State: _____ Zip: _____ - _____ (9 digits)</p> <p>County: _____</p> | | |
| <p>16b. Contact Name/Title:</p> <p>Name: _____</p> <p>Title: _____</p> | <p>16c. Contact E-Mail Address:</p> | |
| <p>16d. Contact Phone:</p> <p>()</p> | <p>16e. Contact Toll-Free Phone:</p> <p>()</p> | <p>16f. Contact Fax Number:</p> <p>()</p> |
| <p>17. Business Type: (Check 1 Box Only)</p> <p><input type="checkbox"/> Business Corporation, For Profit <input type="checkbox"/> Not For Profit <input type="checkbox"/> Sole Proprietorship</p> <p><input type="checkbox"/> Estate/Trust <input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Government Owned <input type="checkbox"/> Public Service Corporation</p> | | |
| <p>18.</p> <p>a. License Number: _____ b. Issuing State: _____</p> <p>c. Issue Date: _____ d. Expiration Date: _____</p> <p>*A copy of your license is required for your application to be processed.</p> | | |
| <p>19. Drug Enforcement Agency (DEA) Number: _____</p> <p>*If you have a DEA number, a copy of your DEA certificate is required for your application to be processed.</p> | | |
| <p>20. CMS Certification number: _____</p> <p>*A copy of your CMS certification is required for your application to be processed.</p> <p>Note: NEW individual providers only- To add additional service locations upon INITIAL enrollment only, refer to page 12. Copy as needed and fill out for each service location you wish to add.</p> | | |
| <p>12/2/11</p> | | <p>8</p> |

21a. Service Location Address: (A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ - _____ (9 digits) County: _____

Business Phone: _____ Fax Number: _____
() _____ - _____ () _____ - _____

Is this address an active Rural Health Clinic or FQHC? Yes No

Check all applicable boxes. This service location is also a: Pay-to Mail-to Home Office
If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #25.

IF you wish to utilize the **Electronic Funds Transfer Direct Deposit Option** please follow link for further information:
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm>

21b. Would you like to receive E-Mail notification of new bulletins? Yes *No

E-Mail address is required if answered YES to receive notification of MA bulletins: _____

*By answering NO you are agreeing to be responsible to check for new MABs on your own by visiting the following website:
<http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm> OR by signing up to receive notification of new MABs through the Listserv option on the DPW website: <http://www.dpw.state.pa.us/provider/index.htm> (select 'eBulletins' Listserv option to join).

IF you wish to continue receiving paper bulletins call 1.800.537.8862 option 1 to see if you meet the requirements.

21c. Once enrolled, you can retrieve RAs from PROMiSe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

21d. Check this block only if you wish your Medicare claims to crossover to this service location.

21e. Contact Name: _____ Contact Phone: _____

Title: _____

21f. Contact Toll-Free Phone:

21g. Contact Fax Number:

21h. Contact E-Mail address:

21i. In addition to English do you or your staff communicate with patients in another language?
Yes No

21j. If "Yes", list language(s):

- 21k. (1) Does the office have exterior or interior steps leading to the main entrance doorway?
Yes No Exterior Interior
- (2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?
Yes No Permanent Portable
- (3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes No
No exterior steps No interior steps
Permanent ramp Portable ramp
- (4) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities Act (ADA)? If yes, attach a copy of the exemption to your application.
Yes No

21l. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

22. Does the provider retain any managing employees or agents? Yes * No
IF "YES" please complete Attachment I (Managing Employee or Agent Disclosure Form) found here:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf

12/2/11

9

23. CONFIDENTIAL INFORMATION

Have you, any agent, or managing employee ever:

- A. Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?
 Yes No
- B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?
 Yes No
- C. Had a controlled drug license withdrawn?
 Yes No
- D. Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?
 Yes No
- E. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?
 Yes No

23F.

If you answered "Yes" to any of the questions listed above, you MUST provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:

- | | |
|--|---|
| 1. Name and title of individual | 8. Disposition/State |
| 2. Name of federal or state health care program | 9. Date license was surrendered |
| 3. Name of licensing/certifying agency taking the action | 10. Name of court |
| 4. Date of action | 11. Date of conviction |
| 5. Type of action taken | 12. Offense(s) convicted of |
| 6. Length of action | 13. Sentence(s) |
| 7. Basis for action | 14. Categorization of offense (e.g. felony, misdemeanor) |

24. This form requires the original signature of the individual applying for enrollment.

Title

Printed Name

Original Signature

Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 21a

NOTE: Do not use this sheet to add service locations.

| | | |
|---|-------------------------------|---------------------------|
| 25 a. Address: Street _____ Suite/Box _____ City _____ State _____ Zip (9-digits) _____ County _____ | | |
| b. This address is a: <input type="checkbox"/> Mail-to <input type="checkbox"/> Pay-to <input type="checkbox"/> Home Office | c. E-Mail address: _____ | |
| d. Contact Name/Title: Name: _____ Title: _____ | | |
| e. Business Phone: () | f. Toll-Free Phone () | g. Fax Number: () |
| | | |
| a. Address: Street _____ Suite/Box _____ City _____ State _____ Zip (9-digits) _____ County _____ | | |
| b. This address is a: <input type="checkbox"/> Mail-to <input type="checkbox"/> Pay-to <input type="checkbox"/> Home Office | c. E-Mail address: _____ | |
| d. Contact Name/Title: Name: _____ Title: _____ | | |
| e. Business Phone: () | f. Toll-Free Phone () | g. Fax Number: () |
| | | |
| a. Address: Street _____ Suite/Box _____ City _____ State _____ Zip (9-digits) _____ County _____ | | |
| b. This address is a: <input type="checkbox"/> Mail-to <input type="checkbox"/> Pay-to <input type="checkbox"/> Home Office | c. E-Mail address: _____ | |
| d. Contact Name/Title: Name: _____ Title: _____ | | |
| e. Business Phone: () | f. Toll-Free Phone () | g. Fax Number: () |
| 12/2/11 | | |
| 11 | | |

Note: NEW individual providers only- To add additional service locations upon INITIAL enrollment copy this page as needed and fill out for each service location you wish to add.

1. Service Location Address: (A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ - _____ (9 digits) County: _____

Business Phone: _____ Fax Number: _____
 () _____ - _____ () _____ - _____

Is this address an active Rural Health Clinic or FQHC? Yes No

Check all applicable boxes. This service location is also a: Pay-to Mail-to Home Office
 If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #25.

2. Add rendering provider to: Existing provider group number: _____ (13 digits)
 Add rendering provider to: new provider group applicant group name: _____

3. Specialty(s) and Code(s), if applicable:

Specialty: _____

Code Number: _____ (3 digits)

4. Sub-Specialty(s) and Code(s), if applicable:

Sub-Specialty(s): _____

Code Number(s): _____ / _____ (3 digits)

5. If the taxonomy(s) for this service location differ(s) from the service location on page 1, block 3 please provide the taxonomy(s) for this particular service location:

Taxonomy(s): _____ (10 digits) _____ (10 digits) _____ (10 digits)

6. Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

7. Check this block only if you wish your Medicare claims to crossover to this service location.

8. Contact Name: _____ Contact Phone: _____

Title: _____

9. Contact Toll-Free Phone:
 () _____

10. Contact Fax Number:
 () _____

11. Contact E-Mail address:

12. (1) Does the office have exterior or interior steps leading to the main entrance doorway?

Yes No Exterior Interior

(2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?

Yes No Permanent Portable

(3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?

Yes No

No exterior steps No interior steps

Permanent ramp Portable ramp

(4) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities Act (ADA)? If yes, attach a copy of the exemption to your application.

Yes No

13. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. You must choose at least 1 PEP:

a. _____ b. _____ c. _____

12/2/11

12

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS**

PROVIDER AGREEMENT FOR OUTPATIENT PROVIDERS

1. This is to certify that _____

(PROVIDER NAME)

agrees to participate in the Pennsylvania Medical Assistance Program on the following terms:

2. The provider shall comply with all applicable State and Federal laws regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.

3. Specifically, and without limitations, the provider shall:
 - A. Keep any records necessary to disclose the extent of services the provider furnishes to recipients;

 - B. Upon request, furnish to the Department of Public Welfare, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under paragraph (A) above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program; and

 - C. Comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.

4. This agreement shall continue in effect unless and until it is terminated by either the provider or the Department. Either the provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

PROVIDER

By: _____

(Original Signature)

(Date)

(Name – Please Type or Print)

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and **submit it with your application**. Incomplete applications will be returned.

Please remember applications will be scanned - do not staple.

Did you remember to....

- USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.**
- Complete all spaces** as required on the application with either your correct information or N/A.
- Complete the Provider Disclosure/Ownership or Control interest form; found here:**
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf
- Ensure that you have entered the **correct number of digits** where specified.
- If you have more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- Indicate **one primary** provider type, provider specialty and sub-specialty(s), as applicable.
- Include a copy of your **Social Security card, W-2 or any document generated by the Federal IRS** showing your name and SS number. If the Social Security card states "Valid for work only with INS authorization", please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- Include **documentation generated by the Federal IRS** showing the name associated with the FEIN. Remember, a **W-9 is not permissible**.
- Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- If applicable, **include a copy** of your:
 - Professional license
 - CLIA certificate
 - Mammography certificate, including the list of mammography certified members and their PROMISE™ 13 digit provider numbers
 - Permit from the Department of Health
 - Any other certification, license, or permit that applies.
- Include a legible copy of your **DEA certificate**, if applicable.
- Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the entity applying for enrollment.
- Enter **at least 1** Provider Eligibility Program (PEP).
- Show proof of home state Medicaid participation (out of state providers only).
- Only the **person applying for enrollment or a representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement. Signature stamp not accepted.**

When completed, review the "Did You Remember..." Checklist included with the application.

Then return your application and other documentation **TO THE ADDRESS LISTED ON THE REQUIREMENTS FOR YOUR SPECIFIC PROVIDER TYPE**. If no address is listed on the requirements for your specific provider type/specialty, please mail to:

DPW Enrollment Unit PO Box 8045 Harrisburg, PA 17105-8045

12/2/11

14

Appendix (C)(12)

HCBS Waiver Provider Agreement

OLTL – HCBS WAIVER AGREEMENT *

Home and Community Based Services for:

(Check as appropriate)

- | | |
|--|--|
| <input type="checkbox"/> OBRA Waiver | <input type="checkbox"/> Attendant Care/ACT 150 Waiver |
| <input type="checkbox"/> Independence Waiver | <input type="checkbox"/> AIDS Waiver |
| <input type="checkbox"/> COMMCARE Waiver | <input type="checkbox"/> Aging Waiver |

This AGREEMENT and Rider A made this the _____ day of _____, 20____, between the Commonwealth of Pennsylvania, Department of Public Welfare, herein referred to as the "Department" and _____ herein referred to as the "Provider" sets forth the terms of participation in the approved Medicaid Waiver Program, herein referred to as the "Program".

1. The Provider agrees to participate in the Program and to know and to comply with all applicable Federal and State laws and regulations including the Commonwealth's Contract Compliance Regulations as set forth at 16 Pa. Code §§ 49.101 et seq.
2. The Provider is responsible for determining that the individual to be served has a current valid Medicaid Services Eligibility card.
3. The Provider shall certify that the services or items for which payment is claimed were actually provided to the person identified as the recipient; that the claim does not exceed the Provider's customary charge for the same or equivalent services or items provided to persons who are not Medicaid recipients; that the claim is correctly coded in accordance with billing instructions prescribed by the Department; and, that all information submitted in support of the claim is true, accurate and complete.
4. The Provider agrees to:
 - a. Keep records necessary to disclose the nature and extent of services provided recipients.
 - b. provide this record information, as requested, to the Department, and its Medicaid fraud control unit, United States Department of Health and Human Services and also provide any information needed regarding payments the Provider has claimed under the Medicaid State Plan.
5. The Provider will be reimbursed in accordance with the rates established by the Department for services provided in compliance with the requirements of the approved Home and Community Based Services for Nursing Facility Recipients with Other Related Conditions Waiver.
6. The effective date of this Agreement shall be the date that the Department enters the Provider's name into the Medical Assistance Management Information System. This Agreement will continue from the effective date until it is terminated by either party.
7. The Provider may terminate this Agreement without cause by providing 60 calendar days written notice to the Department.
8. All disputes concerning this Agreement, its termination or any breach thereof shall be referred to the Department's Office of Hearings and Appeals for adjudication.

*Under the terms of this Provider Agreement, all full-time and part-time employees of the provider agency or individuals delivering services through individual service agreements with a qualified provider agency must also meet the OLTL Standards for Provider Participation and all other policies to safeguard the health and welfare of waiver recipients. Individuals who meet the Standards for Provider Participation, but do not have individual service agreements with qualified provider agencies, must have Provider Agreements directly with the Office of Medical Assistance Programs and the Office of Long-Term Living.

Provider's Signature

Date

Title

RIDER A TO THE OLTL – HCBS WAIVER PROVIDER AGREEMENT

Provider compliance with the following Minimum Protection Assurances is an integral part of maintaining the Provider's Medical Assistance Provider Agreement.

MINIMUM PROTECTION ASSURANCES

1. The Provider, _____, assures that he/she has never been convicted of a felony involving physical harm to a person which includes but is not limited to homicide, rape, aggravated assault, robbery and arson.
2. The Provider, _____, assures that he/she has not, within the five years immediately preceding the date of his/her enrollment in the Waiver Program, been convicted of a felony not involving physical harm to a person which includes but is not limited to grand theft, distribution of controlled substances, extortion, embezzlement, fraud or burglary.
3. The Provider, _____, has not, within five years immediately preceding the date of his/her enrollment in the Waiver Program, been named on any central registry as a perpetrator of a founded or indicated report of child abuse.
4. The Provider, _____, assures that he/she will not be unjustly enriched as a result of any financial arrangement (such as owner-lease kickbacks) with the recipient receiving supports. This includes but is not limited to the Provider receiving gifts from the recipient or being named as the beneficiary on the recipient's life insurance policies. The recipient's life insurance policy assurance does not apply to the recipient's spouse, children or other relatives.
5. The Provider, _____, assures that it will not restrict an individual's freedom of choice to be served by any qualified Provider under the Waiver and will freely provide each individual with information on other providers upon request.
6. The Provider, _____, assures that he/she will make every reasonable effort to provide Waiver services of satisfactory quality, under recipient's direction and in accordance with his/her Personal Support Plan.
7. The Provider, _____, assures that it will complete the training requirements and all other obligations specified in the Department's Standards for Provider Participation.

Provider's Signature

Date

(Name – Please type or print)

Appendix (C)(13)

Provider Enrollment Form: COMMCARE, Independence & OBRA

Provider Enrollment Information Form Home and Community Based Services COMMCARE, INDEPENDENCE & OBRA

Provider Name: _____ MPI #: _____

Requested Waiver(s): COMMCARE INDEPENDENCE OBRA

OLTL must be provided with job description for each service checked on this form.

Type of services to be provided: (Check appropriate boxes)

In Home Habilitation Services:

- Personal Assistance Services (PAS) – Agency [W1793]
- Personal Assistance Services (PAS) – Clustered Shared Living Arrangement (CSLA) [W1793 TT] *Indep. & OBRA waivers only*
- Respite - Agency [T1005]
- Community Integration [97537]

Home Health Services:

- Registered Nurse (RN) [T1002 SE]
- License Practical Nurse (LPN) [T1003 SE]
- Occupational Therapy (T2025 GO)
- Occupational Therapy Assistant (T2025 GO U4)
- Physical Therapy (T2025 GP)
- Physical Therapy Assistant (T2025 GP U4)
- Speech Therapy (T2025 GN)

Out of Home Habilitation Services:

- Adult Daily Living Services (S5102)
- ½ Day Adult Daily Living (S5102 U5)
- Enhanced Adult Daily Living (S5102 U4)
- Prevocational Services (W6107) *COMMCARE and OBRA waivers only*
- Supported Employment (W6106)

Residential Habilitation and Structure Day: COMMCARE and OBRA only

Supplemental Services cannot be selected without a corresponding group setting service

- Residential Habilitation in a 1-3 group setting (W0100)
 - Res. Habilitation Supplemental for 1:1 (W0101 U4)
 - Res. Habilitation Supplemental for 2:1 (W0101 U5)
- Residential Habilitation in a 4-8 group setting (W0104)
 - Res. Habilitation Supplemental for 1:1 (W0105 U4)
 - Res. Habilitation Supplemental for 2:1 (W0105 U5)
- Structured Day Habilitation-Group (W0102)
 - Structured Day Supplemental for 1:1 (W0103 U4)
 - Structured Day Supplemental for 2:1 (W0103 U5)

Therapeutic and Counseling Services:

- Behavioral Therapy (H2019)
- Cognitive Therapy (97532 SE)
- Counseling Services (H0004)
- Nutritional Counseling (S9470 AE U4)

Vendor Services:

These services must be provided by your agency directly unless you are a Service Coordination Agency that is an Organized Health Care Delivery System (OHCDs) Member

- Accessibility Adaptations (multiple procedure codes)
- Durable Medical Equipment & Supplies (T2029)
- Non-Medical Transportation (W6110)
- Personal Emergency Response Sys. – Maintenance (W1895)
- Personal Emergency Response Sys. – Installation (W1894)

**Provider Enrollment Information Form
Home and Community Based Services
COMMCARE, INDEPENDENCE & OBRA**

Please indicate the counties that you are willing and able to provide services in:

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Requested effective date: _____

Signature of Authorized Representative

Title

Print Name

Date

Staff qualifications needed to provide that service can be found in each individual waiver.
http://www.aging.state.pa.us/portal/server.pt/community/information_for_families_and_individuals/19326/support_services_waiver_information/733116

If your agency is interested in providing Service Coordination, please send an email with request for information to ra-hcbsevenprov@pa.gov.

Revised 3/15/2013

Appendix (C)(14)

Provider Enrollment Form: Aging Waiver

Provider Enrollment Information Form Home and Community Based Services AGING WAIVER

Provider Name: _____ MPI #: _____

OLTL must be provided with the job description for each service checked on this form.

Type of services to be provided: (Check appropriate boxes. Only Services under one Provider Type may be selected)
Appropriate licensure is required for certain provider types

Extended Care Facility (Provider Type 03) *all services are provided within the facility*

- | | |
|---|--|
| <input type="checkbox"/> Respite Care | <input type="checkbox"/> Adult Daily Living Services |
| <input type="checkbox"/> Enhanced Adult Daily Living Services | <input type="checkbox"/> ½ Day Adult Daily Living Services |

Home Health Agency (Provider Type 05) – Must be Medicare Certified

- | | |
|--|---|
| <input type="checkbox"/> DME/Medical Supplies | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Physical Therapy Assistant |
| <input type="checkbox"/> Licensed Practical Nurse (LPN) | <input type="checkbox"/> Private Duty Nursing |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Registered Nurse (RN) |
| <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Personal Assistance Service (PAS) | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Personal Emergency Response System (PERS) | |

DME/Medical Supplies (Provider Type 25)

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> DME/Medical Supplies | <input type="checkbox"/> Telecare |
|---|-----------------------------------|

Adult Day Care (Provider Type 41)

- | | |
|---|--|
| <input type="checkbox"/> Adult Daily Living Services | <input type="checkbox"/> ½ Day Adult Daily Living Services |
| <input type="checkbox"/> Enhanced Adult Daily Living Services | |

Vendor (Provider Type 55)

- | | |
|---|---|
| <input type="checkbox"/> Accessibility Adaptations | <input type="checkbox"/> Personal Assistance Service |
| <input type="checkbox"/> DME/Medical Supplies | <input type="checkbox"/> Personal Emergency Response System |
| <input type="checkbox"/> Home Delivered Meals | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Non-Emergency Transportation | |

Clinic (Provider Type 11)

- Counseling Services – Licensed Social Worker

Therapist (Provider Type 17)

- Therapy (Agency)

Psychologist (Provider Type 19)

- Counseling – General Psychologist

Nutritionist (Provider Type 23)

- Nutritional Counseling – Registered Nutritionist

Pharmacy (Provider Type 24)

- Telecare

Transportation (Provider Type 26)

- Non-Emergency Transportation

**Provider Enrollment Information Form
Home and Community Based Services
AGING WAIVER**

Please indicate the counties that you are willing and able to provide services in:

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Requested effective date: _____

Signature of Authorized Representative

Title

Print Name

Date

Staff qualifications needed to provide that service can be found in each individual waiver.
http://www.aging.state.pa.us/portal/server.pt/community/information_for_families_and_individuals/19326/support_services_waiver_information/733116

Revised 3/15/2013

Appendix (C)(15)

Provider Enrollment Form: Attendant Care & Act 150

**Provider Enrollment Information Form
Home and Community Based Services
ATTENDANT CARE WAIVER & ACT 150 PROGRAM**

Provider Name: _____ **MPI #:** _____

OLTL must be provided with the job description for each service checked on this form.

Type of services to be provided: (Check appropriate boxes)

Attendant Care Waiver

- Personal Assistance Services (PAS) – Agency (W1793)
- Personal Emergency Response Systems (PERS) – Installation (W1894)
- Personal Emergency Response Systems (PERS) – Maintenance (W1895)

Act 150 Program

- Personal Assistance Services (PAS) – Agency (W1793)
- Personal Emergency Response Systems (PERS) – Installation (W1894)
- Personal Emergency Response Systems (PERS) – Maintenance (W1895)

Please indicate the counties that you are willing and able to provide services in:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Requested effective date: _____

Signature of Authorized Representative

Title

Print Name

Date

Definitions of the qualifications needed to provide that service can be found in each individual waiver.
http://www.aqing.state.pa.us/portal/server.pt/community/information_for_families_and_individuals/19326/support_services_waiver_information/733116

If your agency is interested in providing Service Coordination, please send an email with request for information to ra-hcbseprov@pa.gov.

Revised 3/15/2013

Appendix (C)(16)

Provider Enrollment Form: Service Coordination

**Provider Enrollment Information Form
Home and Community Based Services
SERVICE COORDINATION**

Provider Name: _____ **MPI #:** _____

OLTL must be provided with the job description for each service checked on this form.

I wish to become a Service Coordinator for the following waivers (check all that apply):

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aging | <input type="checkbox"/> Independence |
| <input type="checkbox"/> Attendant Care / Act 150 Program | <input type="checkbox"/> OBRA |
| <input type="checkbox"/> COMMCARE | |

Please indicate the counties that you are willing and able to provide services in:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Requested effective date: _____

Signature of Authorized Representative

Title

Print Name

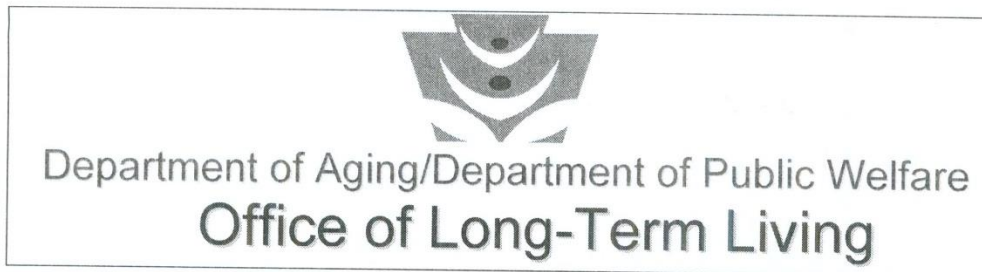
Date

Definitions of the service and qualifications needed to provide that service can be found in each individual waiver.
http://www.aging.state.pa.us/portal/server.pt/community/information_for_families_and_individuals/19326/support_services_waiver_information/733116

Revised 3/27/2013

Appendix (C)(17)

Provider Enrollment Form: OHCDS



Organized Health Care Delivery System (OHCDS) Provider Enrollment Form

By submitting this enrollment form _____ (Agency) seeks designation from the Office of Long-Term Living (OLTL) to be a member of an Organized Health Care Delivery System (OHCDS). As a member of the OHCDS, _____ (agency) will have authorization to subcontract with or reimburse qualified providers for certain services provided under OLTL waiver programs. By submitting this form, the agency agrees that:

1. The Agency shall comply with all applicable state and federal statutes, regulations, policies and announcements that pertain to participation in the Pennsylvania Medical Assistance Program including OLTL Waivers.
2. The Agency shall accept the Waiver payment as payment in full for the service rendered and shall not seek any additional payment from a waiver participant under any circumstances.
3. The Agency shall be responsible for the accuracy of all claims submitted under his or her Agency number, whether submitted by the Agency or on the Agency's behalf.
4. The Agency shall not bill or receive payment for services that are not authorized in the Individual Service Plan (ISP).
5. The Agency acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions, including exclusion from participation in Medicare, the Pennsylvania Medical Assistance Program, other State Medicaid programs, and all other Federal and State health care programs.
6. The Agency shall comply with the disclosure requirements specified in federal regulations at 42 CFR Chapter 455, Subpart B (relating to disclosure of information by Providers and fiscal agents).
7. The Agency shall submit claims for Waiver services in accordance with instructions issued by the Department.
8. The Agency shall comply with all federal audit requirements, including the Single Audit Act, 31 U.S.C. §§ 7501-7507; the revised Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Government, and Non-Profit Organizations; 45 CFR § 74.26 (relating to non-federal audits); and any other applicable statutes or regulation.
9. If the Agency is subcontracting or reimbursing the cost of the service provided by a provider or vendor under the Waiver, the cost billed by the Agency may not exceed the cost charged by the vendor.

OHCDS Provider Enrollment Form

Agency Name: _____

Medical Assistance (PROMISE) Provider Number: _____

Address of the Provider shown in number one above:

_____ Street
 _____ City _____ State _____ Zip Code
 _____ County _____ (_____) Phone _____

Identify how your agency **will provide** the following services under OHCDS.
 (Check the appropriate box)

| | Directly Providing | Subcontracting |
|------------------------------------|--------------------|----------------|
| Environmental Modifications | | |
| Home Delivered Meals | | |
| Personal Emergency Response System | | |
| Transportation (non-medical) | | |
| Durable Medical Equipment | | |
| Community Transition Services | | |

I certify that the information provided on this Enrollment Information Form is true to the best of my knowledge.

 Signature of Authorized Representative Title Date

9/28/2012

Appendix (C)(18)

Provider Disclosure Form

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database. All information entered is maintained according to Federal HIPAA and privacy regulations. For your reference, please visit the link below for Medical Assistance Bulletin (MAB) 99-11-05. This bulletin applies to all providers enrolling in the MA Program.

<http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4718>

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following forms. If you cannot report all of the necessary information in a designated section of the form because of space limitations, please print and attach additional sheets.

DEFINITIONS

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner), or a fiscal agent.

Any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act means:

- a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- b. Any Medicare intermediary or carrier; and
- c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Individual practitioner means a physician or other person licensed or certified under State Law to practice his or her profession.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that –

- a. Has an ownership interest totaling 5 percent or more in a disclosing entity;
- b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

- e. An officer or director of a disclosing entity that is organized as a corporation; or
- f. Is a partner in the disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means –

- a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Please return completed document and any applicable application to the address listed below:

DPW Enrollment Unit
PO Box 8045
Harrisburg, PA 17105-8045

*If you are a non-profit organization please skip this section and complete Attachment II.

**This is the contact name and phone number we will use if we have any questions about this document.

Contact Name: _____ Provider Name: _____

Phone: _____ E-Mail Address: _____

OWNERSHIP OR CONTROL INTEREST

Note: Ownership and Controlling Interest information is required in accordance with Federal Regulations 42 CFR, Part 455 published July 17, 1979, and expanded through additional subparts on February 02, 2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act.

Please enter the full name and address of partners, stockholders, corporate owners, or officers that have at least 5% direct or indirect ownership interest.

Complete below for INDIVIDUALS:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

****ATTACH ADDITIONAL SHEETS IF NECESSARY****

Ownership or Control Interest (Cont'd)

Complete below for CORPORATE ENTITIES:

****The address for each corporate entity MUST include: primary business address, every business location, and P.O. Box address – Use space provided below or attach a separate sheet of paper if needed.**

Name of Corporation: _____ FEIN/Tax ID number: _____

Street Address: _____ PO Box _____

City: _____ State: _____ Zip Code: _____

Name of Corporation: _____ FEIN/Tax ID number: _____

Street Address: _____ PO Box _____

City: _____ State: _____ Zip Code: _____

Name of Corporation: _____ FEIN/Tax ID number: _____

Street Address: _____ PO Box _____

City: _____ State: _____ Zip Code: _____

****ATTACH ADDITIONAL SHEETS IF NECESSARY****

Ownership or Control Interest (Cont'd)

Please enter the full name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

****Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? Yes * No**
If "YES" please attach details.

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

****Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? Yes * No**
If "YES" please attach details.

****ATTACH ADDITIONAL SHEETS IF NECESSARY****

Are any of the aforementioned persons related to each other as a spouse, parent, child or sibling? If so, please list the names of the individuals and how they are related.

Names: _____

Relationship: _____

Names: _____

Relationship: _____

ATTACHMENT I

Managing Employee or Agent Disclosure Form

A. Please Provide the name, address, social security number, and date of birth of any person who is an agent or managing employee of the provider.

Is the following individual a: **Managing employee** or **Agent**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Is the following individual a: **Managing employee** or **Agent**

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

B. Please Provide the name, and description of offense of any person who is an agent or managing employee and has been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program.

Name: (First) (Middle) (Last)

Description of Offense:

Name: (First) (Middle) (Last)

Description of Offense:

ATTACHMENT II

Non-Profit Disclosure

Please add anyone who has a Controlling interest or is a Board Member.

President:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Vice President:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Secretary:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Treasurer:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

ATTACHMENT II cont.

Other:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Name: (First) (Middle) (Last) SOCIAL SECURITY NUMBER:

Date of Birth: Street Address:

City: State: Zip Code:

Please return completed document and any applicable application to the address listed below:

DPW Enrollment Unit
PO Box 8045
Harrisburg, PA 17105-8045

Appendix (C)(19)

Ordering Forms

The following sections detail the various forms providers may need when billing PA PROMISe™ and the addresses, telephone numbers, and website, when available, for obtaining these forms.

Medical Assistance Forms

Providers may order MA forms via the MA 300X (MA Provider Order Form) or by accessing DPW's website site at:

<http://www.dpw.state.pa.us/dpwassets/maforms/index.htm>

For providers who do not have access to the Internet, the MA 300X can be ordered directly from DPW's printing contractor:

Department of Public Welfare
MA Forms Contractor
P.O. Box 60749
Harrisburg, PA 17106-0749

Additionally, providers can obtain an order form by submitting a request for the MA 300X, in writing, to:

Department of Public Welfare
Office of Medical Assistance Programs
Division of Operations
P.O. Box 8050
Harrisburg, PA 17105

You can expect to receive your forms within two weeks from the time you submit your order. This quick turnaround time on delivery is designed to eliminate the need for most emergencies. You should keep a three to six month supply of extra forms, including order forms, on hand and plan your ordering well in advance of exhausting your supply.

The MA 300X can be typed or handwritten. Photocopies and/or carbon copies of the MA 300X are not acceptable. Orders must be placed on an original MA 300X.

The MA 300X is continually being revised as forms are added or deleted. Therefore, you may not always have the most current version of the MA 300X form from which to order. You need to be cognizant of MA Bulletins and manual releases for information on new, revised, or obsolete forms so that you can place your requisitions correctly. If a new MA form is not on your version of the MA 300X, you are permitted to add the form to the MA 300X.

Please note that forms specific to services administered by the Office of Mental Health and Substance Abuse Services may not be available for ordering using the MA 300. Please contact OMHSAS via email at HC-Services@pa.gov or you may call OMHSAS Provider Inquiry at 800-433-4459.

CMS-1500 Claim Form

DPW does not provide CMS-1500 claim forms. Providers may review the information listed below to obtain CMS-1500 claim forms for paper claim form submission.

To obtain copies of the CMS-1500 claim form:

- Contact the US Government Printing Office at (202) 512-1800 or your local Medicare carrier. You may access the website at <http://bookstore.gpo.gov>. For a list of local Medicare carriers in your state, including their telephone number, please go to the Medicare Regional Homepage.
- You contact the American Medical Association Unified Service Center at 800-621-8335.

Appendix (D)(1)

County Assistance Office (CAO) Contact List

See CAO Contact List at:

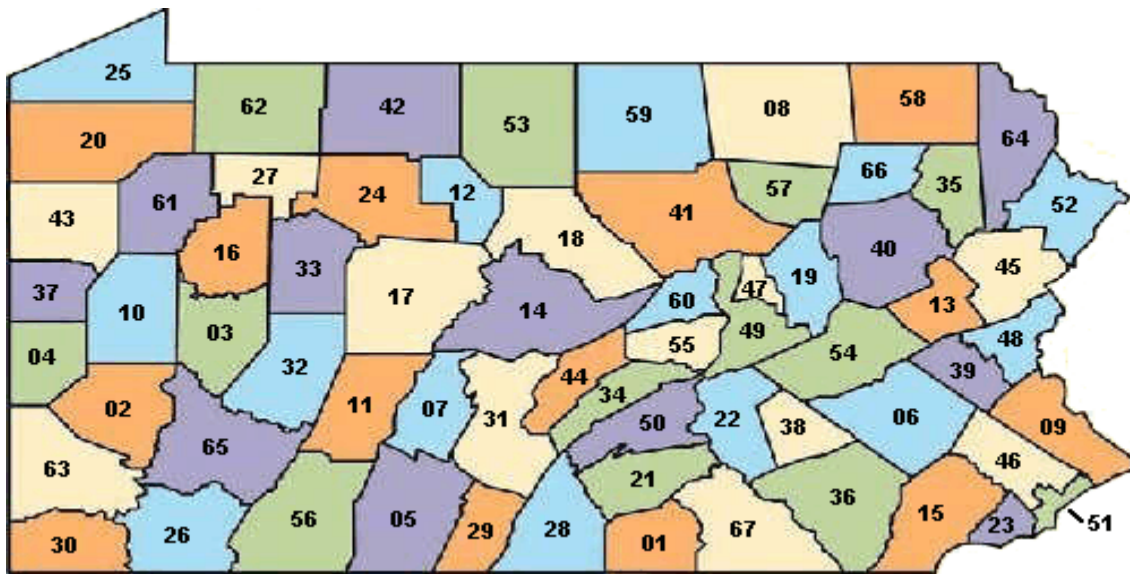
<http://www.dpw.state.pa.us/findfacilsandlocs/countyassistanceofficecontactinformation/index.htm>

Appendix (D)(2)

Area Agencies On Aging Map

<http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616534&mode=2>

Looking for information on what programs and services are available in your community? The best place to start is with your local [Area Agency on Aging](#). Click on your county of residence in the list below for specific Area Agencies on Aging listings.



- | | | | |
|--------------------------------|--------------------------------|------------------------------------|----------------------------------|
| 01. Adams | 18. Clinton | 35. Lackawanna | 52. Pike |
| 02. Allegheny | 19. Columbia | 36. Lancaster | 53. Potter |
| 03. Armstrong | 20. Crawford | 37. Lawrence | 54. Schuylkill |
| 04. Beaver | 21. Cumberland | 38. Lebanon | 55. Snyder |
| 05. Bedford | 22. Dauphin | 39. Lehigh | 56. Somerset |
| 06. Berks | 23. Delaware | 40. Luzerne | 57. Sullivan |
| 07. Blair | 24. Elk | 41. Lycoming | 58. Susquehanna |
| 08. Bradford | 25. Erie | 42. McKean | 59. Tioga |
| 09. Bucks | 26. Fayette | 43. Mercer | 60. Union |
| 10. Butler | 27. Forest | 44. Mifflin | 61. Venango |
| 11. Cambria | 28. Franklin | 45. Monroe | 62. Warren |
| 12. Cameron | 29. Fulton | 46. Montgomery | 63. Washington |
| 13. Carbon | 30. Greene | 47. Montour | 64. Wayne |
| 14. Centre | 31. Huntingdon | 48. Northampton | 65. Westmoreland |
| 15. Chester | 32. Indiana | 49. Northumberland | 66. Wyoming |
| 16. Clarion | 33. Jefferson | 50. Perry | 67. York |
| 17. Clearfield | 34. Juniata | 51. Philadelphia | |

Appendix (D)(3)

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) became public law on August 21, 1996. It is a federal bi-partisan law based on the Kennedy-Kassebaum bill. The Department of Health and Human Services assigned the Centers for Medicare & Medicaid Services (CMS) the task of implementing HIPAA. The primary goal of the law was to make it easier for people to keep health insurance, and help the industry control administrative costs.

HIPAA is divided into five Titles or sections. Title I is Portability and has been fully implemented. Portability allows individuals to carry their health insurance from one job to another so that they do not have a lapse in coverage. It also restricts health plans from imposing pre-existing condition limitations on individuals who switch from one health plan to another.

Title II is called Administrative Simplification. Title II is designed to:

- Reduce health care fraud and abuse;
- Guarantee security and privacy of health information;
- Enforce standards for health information and transactions; and
- Reduce the cost of healthcare by standardizing the way the industry communicates information.

Titles III, IV, and V have not yet been defined.

The main benefit of HIPAA is standardization. HIPAA requires the adoption of industry-wide standards for administrative health care transactions; national code sets; and privacy protections. Standards have also been developed for unique identifiers for providers, health plans and employers; security measures; and electronic signatures.

HIPAA Privacy

The HIPAA Privacy Rule became effective on April 14, 2001, and was amended on August 14, 2002. It creates national standards to protect medical records and other protected health information (PHI) and sets a minimum standard of safeguards of PHI.

The regulations impact covered entities that are health care plans, health care clearinghouses and health care providers. Most covered entities, except for small health plans, must comply with the requirements by April 14, 2003. DPW performs functions as a health care plan and health care provider. Any entity having access to PHI must do an analysis to determine whether it is a covered entity and, as such, subject to the HIPAA Privacy Regulations.

Requirements

Generally, the HIPAA Privacy Rule prohibits disclosure of PHI except in accordance with the regulations. All organizations which have access to PHI must do an analysis to determine

whether or not it is a covered entity. The regulations define and limit the circumstances under which covered entities may use or disclose PHI to others. Permissible uses under the rules include three categories:

1. Use and disclosure for treatment, payment and healthcare operations;
2. Use and disclosure with individual authorization; and
3. Use and disclosure without authorization for specified purposes.

The HIPAA Privacy Regulations require Covered Entities to:

- Appoint a privacy officer charged with creating a comprehensive Privacy Policy.
- Develop minimum necessary policies.
- Amend Business Associate contracts.
- Develop accounting of disclosures capability.
- Develop procedures to request alternative means of communication.
- Develop procedures to request restricted use of PHI.
- Develop complaint procedures.
- Develop amendment request procedures.
- Develop individual access procedures.
- Develop an anti-retaliation policy.
- Train the workforce.
- Develop and disseminate the Privacy Notice.

Business Associate Relationships

As a covered entity, DPW must have safeguards in place when it shares information with its

Business Associates- A Business Associate is defined by the HIPAA Privacy Regulation as a person or entity, not employed by the covered entity, who performs a function for the covered entity that requires it to use, disclose, create or receive PHI. The covered entity may disclose PHI to a Business Associate if it receives satisfactory assurances that the Business Associate will appropriately safeguard the information in accordance with the HIPAA requirements. These assurances are memorialized in a Business Associate Agreement that may or may not be part of a current contract or other agreement. The Business Associate language must establish permitted and required uses and disclosures and must require Business Associates to:

1. Appropriately, safeguard PHI.

2. Report any misuse of PHI.
3. Secure satisfactory assurances from any subcontractor.
4. Grant individuals access to and the ability to amend their PHI.
5. Make available an accounting of disclosures.
6. Release applicable records to the covered entity and the Secretary of Health and Human Services
7. Upon termination of the Business Associate relationship, return or destroy PHI.

DPW's Business Associates include, but are not limited to Counties, Managed Care Organizations, Children and Youth Agency Contractors, and certain Contractors/Grantees. DPW's agreements with its Business Associates must be amended (or otherwise modified) to include the Business Associate language required for HIPAA compliance. DPW will discontinue sharing information and/or discontinue a relationship with a Business Associate who fails to comply with the Business Associate language.

Notice of Privacy Practice

A covered entity must provide its consumers with a plain language notice of individual rights with respect to PHI maintained by the covered entity. Beginning April 15, 2003, health care providers must provide the notice to all individuals on their first day of service, and must post the notice at the provider's delivery site, if applicable. Except in an emergency treatment situation, a provider must make a good faith effort to obtain a written acknowledgement of receipt of the notice. Health plans must provide the notice to each individual enrolled in the plan as of April 14, 2003, and to each new enrollee thereafter at the time of enrollment, and within sixty days of any material revision to the notice. A covered entity with a website must post its notice on the website. A covered entity must document compliance with the notice requirements and must keep a copy of notices issued.

The specific elements of the notice include:

- Header: "This notice describes how medical information about you may be used and how you can get access to this information. Please review it carefully."
- A description, including at least one example, of the types of uses and disclosures the covered entity may make for treatment, payment or health care operations.
- A description of each of the other purposes for which the covered entity is required or permitted to use or disclose individually identifiable health information without consent or authorization.
- If appropriate, a statement that the covered entity will contact the individual to provide information about health-related benefits or services.
- A statement of the individual's rights under the privacy regulations.

- A statement of the covered entity's duties under the privacy regulations.
- A statement informing individuals how they may complain about alleged violations of the privacy regulations.

Employee Training and Privacy Officer

Providers must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed.

Consent and Authorization

Consent

The HIPAA Privacy Regulations permit (not require) a covered entity to obtain a consent from a patient to use and disclose PHI for treatment, payment and health care operations. DPW will be obtaining consent for treatment, payment, and health care operations from its clients, where practicable.

Authorization

The HIPAA Privacy Regulations make a clear distinction between consents and authorizations. Consents are used only for disclosures related to treatment, payment and health care operations. The covered entity is required to have an authorization from an individual for any disclosure that is not for treatment, payment, or health care operations or exempted under the regulations. An authorization must clearly and specifically describe the information that may be disclosed, provide the name of the person or entity authorized to make the disclosure and to whom the information may be disclosed. An authorization must also contain an expiration date or event, a statement that the authorization may be revoked in writing, a statement that the information may be subject to redisclosure and be signed and dated.

Enforcement

DPW is not responsible for the enforcement of the HIPAA privacy requirements. This responsibility lies with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). The enforcement activities of OCR will involve:

- Conducting compliance review;
- Providing technical assistance to covered entities to assist them in achieving compliance with technical assistance;
- Responding to questions and providing guidance;
- Investigating complaints; and, when necessary,
- Seeking civil monetary penalties and making referrals for criminal prosecution

HIPAA Security Rule

The HIPAA Security Rule sets guidelines for the protection of private information. Security is the policies, procedures, technical services, and mechanisms used to protect electronic information. It mandates computer systems, facility, and user security safeguards. These safeguards are intended to minimize unauthorized disclosures and lost data.

Penalties for Noncompliance

The penalties outlined for the two rules released to date are as follows:

Penalties for the Transactions and Code Sets are aimed at the health plans, billing services and providers who submit claims electronically.

They are:

\$100 per violation (defined as each claim element)

Maximum of \$25,000 per year.

Privacy affects all covered entities, such as health plans, billing services, providers and business associates who receive and use protected health information. The penalties for wrongful disclosures are:

Up to \$250,000 AND

10 years in prison.

For more information on penalties, please go to <http://www.hhs.gov/ocr/hipaa>

Additional HIPAA Information

Located below are some links to pages of the HIPAA section of the DPW Internet site that you can visit for the most up-to-date information on HIPAA.

For General HIPAA information:

<http://www.dpw.state.pa.us/yourprivacyrightshipaa/index.htm>

For Office of Medical Assistance HIPAA information:

<http://www.dpw.state.pa.us/yourprivacyrightshipaa/index.htm>

For HIPAA Compliant Provider Billing Guides:

<http://www.dpw.state.pa.us/publications/forproviders/promisecompanionguides/index.htm>

For information on HIPAA Certification:

<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/softwareandservicevendors/hipaa5010d.0upgradeinformation/index.htm>

Appendix (D)(4)

Eligibility Verification System Quick Tips

PA PROMISE™

Quick Tip **11**

The Eligibility Verification System

The PROMISE™ Eligibility Verification System (EVS) enables you to determine a Medical Assistance recipient's eligibility as well as their scope of coverage. Please do not assume that the recipient is eligible because he/she has an ACCESS card. It is vital that you use EVS to verify eligibility each time you provide a service. **A recipient's eligibility is subject to change; therefore, you should use EVS to verify eligibility each time you provide services to recipients.** All providers serving members of a Voluntary or Health Choices Managed Care Organization should also use EVS. You can access EVS through a variety of access methods as displayed below.

Methods to Access EVS

Telephone:

The Automated Voice Response System (AVRS) accepts requests for and returns eligibility information over a toll-free phone number. Using a touch-tone phone, please call 1-800-766-5387

Bulletin Board System

Eligibility information can be requested by contacting an electronic bulletin board and transmitting and receiving batch files of eligibility requests via a telephone connection. Our Provider Electronic Solution software supports this method.

VAN (PC/POS) Device:

Value Added Network (VAN) vendors collect requests for eligibility information in a real-time interactive processing mode and interface with the PROMISE EVS system. Both PC software and point-of-service (POS) devices use this. Our Provider Electronic Solution software supports this method.

Web Interactive:

A Web eligibility request window is available to approved providers and other agencies via the PROMISE™ website. Log on at <http://promise.dpw.state.pa.us>.

Quick Tip 11

What information does EVS return when service dates are within two years of the current date?

Recipient Demographics: Recipient Name, Recipient ID Number, Gender, Date of Birth.

Eligibility Segments: Begin and End date, Eligibility Status, Category of Assistance, Program Status Code and Service Program Description. Please note that more than one eligibility segment may be returned depending on the dates submitted on the EVS inquiry.

MCO Physical, FCN, LTCCAP: Managed Care Organization (MCO) Physical, Family Care Network (FCN), Long Term Care Capitation Assistance Program (LTCCAP) – Plan name/code and phone #, Primary Care Provider name and phone #, Primary Care Case Manager name and phone #, and Begin and End date (if different from inquiry date).

MCO Behavioral: Managed Care Organization Behavioral – Plan name/code and phone #, Primary Care Provider (PCP) name and phone #, Begin and End dates (up to 3 PCPs may be returned), Begin and End date (if different from inquiry dates).

Restricted Recipient Information: Lock In or Restricted Recipient Information. Status (Yes; No), Provider type to whom the recipient is restricted, Provider name and phone # to whom the recipient is restricted, and Begin and End date (if different from inquiry dates).

TPL–Third Party Liability: Carrier name/type/address, Policyholder name and number (except for Medicare part A or B), Group number, Patient pay amount, and Begin and End dates.

Limitation: Procedure code and NDC (Fee for Service only; unavailable with AVRS).

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment, and last screen date (for under 21 only).

Dental: Last dental visit (for under 21 only).

What information does EVS return when eligibility request services dates are more than two years of current date?

Recipient Demographics: Recipient Name, Recipient ID Number, Gender, Date of Birth.

Eligibility Segments: Begin date and end date, Eligibility status, Category of Assistance, Program Status Code, Service Program description.

Please note that EVS now follows the HIPAA compliant 270/271 eligibility format and no longer provides this information in a proprietary format. Please refer to the OMAP website at www.dpw.state.pa.us/omap for PROMISE™ Eligibility Verification System (EVS) Error Codes that explain the error code description and why the error set.

Appendix (D)(5)

Recipient Benefits

580.6 Pennsylvania EBT ACCESS Card

The Pennsylvania [EBT ACCESS card](#) is an industry-standard plastic card with a magnetic stripe giving recipients access to cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, or Medical Assistance benefits (or any combination of them). Recipients get SNAP benefits electronically through point-of-sale (POS) terminals in authorized food stores. They can get cash assistance through POS terminals and automated teller machines (ATMs). Recipients can verify their eligibility for Medical Assistance through the online Eligibility Verification System (EVS).



For more information on the ACCESS Card please reference Chapter 380 of the Medical Assistance Eligibility Handbook or Chapter 580.6 of the SNAP Handbook at the following links:

<http://oimmanuals/bop/Robo/MA/index.htm>

<http://oimmanuals/bop/Robo/SNAP/index.htm>

Appendix (D)(6)

Utilizing Provider Resources

| Resource | Description | Contact Information |
|--|--|---|
| Aging and Disability Resource Centers (ADRCs) | Pennsylvania ADRCs (Link Offices) were established to increase access to programs and services by linking different state, county, and non-profit staff to provide a one-stop aging and disability resource center for Pennsylvanians. | <p>Allegheny County Link The Human Services Building One Smithfield Street, 1st Fl Pittsburgh, PA 15222 Toll Free: 1-866-570-5465 Website: www.alleghenylink.com/</p> <p>Cumberland County Link 145 South Hanover Street Carlisle, PA 17013 Phone: (717) 240-7887 Toll Free: 1-866-570-LINK TTY: (717) 240-7893 Fax: (717) 243-8005 E-mail: thelink@ccpa.net Website: www.ccpa.net/index.asp?nid=111</p> |
| Area Agencies on Aging (AAAs) | Pennsylvania's 52 AAAs are a great source of information for the issues and concerns affecting older people and their caregivers. Specific services at each AAA vary, but each offers a wide array of programs to help older Pennsylvanians and their families get the help and information they need. | <p>Information about AAAs: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616534&mode=2</p> <p>A list of AAAs in each PA county: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616424&mode=2</p> |
| COMPASS | COMPASS is an online application for Pennsylvanians to apply for health and human service programs such as Long Term Care and Home and Community-Based Services. | <p>COMPASS site: https://www.humanservices.state.pa.us/compass.web/CMHOM.aspx</p> <p>Statewide Customer Service Center toll free number at: 1-877-395-8930</p> |
| County Assistance Offices (CAOs) | Pennsylvania residents can seek assistance and a range of services for themselves and their families from professionally trained staff members at CAOs. | <p>A list of all CAOs: www.dpw.state.pa.us/findfacilsandlocs/countyassistanceofficecontactinformation/index.htm</p> |

| Resource | Description | Contact Information |
|--|--|---|
| DPW, Medical Assistance (MA), Health Choices, and Access Plus | Information related to health care and Medical Assistance. | DPW website: www.dpw.state.pa.us Medicaid/MA, Health Choices, and Access Plus website: www.dpw.state.pa.us/foradults/healthcaremedicalassistance/index.htm |
| Enterprise Incident Management System (EIM) | Web-based system that records, tracks and manages incidences that occur to participants in the under 60 waivers. | Email: RA-OLTL_EIMimplement@pa.gov Website: https://www.hcsis.state.pa.us |
| Fraud and abuse resource | Website and telephone numbers used to report fraud or abuse. | Bureau of Program Integrity http://www.dpw.state.pa.us/dpworganization/officeofadministration/bpi/index.htm MA Provider Compliance Hotline 1-866-DPW-TIPS (1-866-379-8477) |
| HCSIS Help Desk | Provides assistance to all HCSIS users. | Phone: 1-866-444-1264 Fax: (717) 540-0960 Email: c-hhcsishd@state.pa.us |
| LIFE Program Information & Provider List | LIFE is a managed care program for frail elderly recipients who have been determined to need "nursing facility level of care" but wish to remain in their home and community as long as possible. Program specifics are in the waiver description chart. | Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/lifelivingindependenceforthellderly/index.htm |
| Long Term Living Training Institute (LTLTI) of PA | Established by PDA and DPW to ensure that the long-term living network is supported by and retains qualified trained staff. This is accomplished by providing a variety of educational opportunities. | Phone: (717) 541-4214 Fax: (717) 541-4217 Website: http://www.ltltrainingpa.org |

| Resource | Description | Contact Information |
|---|---|---|
| OLTL Bureau of Participant Operations | Waiver program specialists in the Bureau of Participant Operations will address questions pertaining to participants and their service plans. | Phone: (717) 787-8091 |
| OLTL Bureau of Quality and Provider Management Call Center | Hotline open to providers with questions related to Long-Term care service provision and OLTL waivers, e.g., enrollment, billing, additional forms, etc. | Toll free: 1-800-932-0939 (Mon – Thu, 9:00 am - Noon and 1:00 pm – 4:00 pm) Fax: (717) 772-0965 |
| OLTL Bureau of Quality and Provider Management | The BPS Enrollment Section Resource Account inbox can be sent emails from providers who have questions or issues related to OLTL provider enrollment. Please note that this mailbox cannot be used to submit provider enrollment applications. | Email: ra-hcbksenprov@pa.gov |
| OLTL Participant Helpline | Enrolled waiver participants can call with any concerns regarding their services. | Toll Free: 1-800-757-5042 |
| PA Centers for Independent Living | Assists in removing barriers and expanding independent living options available to people with disabilities and the elderly. | A list of all CILs: http://pcil.net/pages/cils/locate_a_cil.aspx |
| PA Code | The Commonwealth's official publication of rules and regulations. | Website: www.pacode.com |
| PA Independent Enrollment Broker | Provides enrollment services for applicants with physical disabilities who are 18-59 years of age applying for Attendant Care, COMMCARE, Independence, OBRA, and the AIDS Waivers and the Act 150 Attendant Care Program. AAAs provide eligibility/enrollment services for applicants over age 60. | Toll free helpline: 1-877-550-4227 TTY: 1-877-824-9346 Fax: (717) 540-6201 Address (for the central office in Harrisburg): PA Independent Enrollment Broker 6385 Flank Drive, Suite 400 Harrisburg, PA 17112-4603 |
| Provider Assistance Center (PAC) | Provides information on direct deposit (electronic funds transfer) EDS/HP. | Toll Free: 1-800-248-2152 |

| Resource | Description | Contact Information |
|--|---|---|
| PROMISe Resources | DPW has a number of PROMISe handbooks and billing guides for all provider types. In addition, OLTL maintains a PROMISe Help Desk for providers. | Information about PROMISe: http://promise.dpw.state.pa.us/ . |
| Bureau of Quality and Provider Management | Provides links to information on monitoring activities coordinated by QPM. | Website: http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/quality/qpm/index.htm |
| Waiver descriptions | List and description of waivers. | Website: http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm |

Appendix (D)(7)

Rate Chart – Fee Schedule Rates

See OLTL Billing Instructions Bulletin at:

<http://www.dpw.state.pa.us/dpworganization/officeoflongtermliving/providers/index.htm>

Appendix (D)(8)

Rate Regions (4)

| Counties Categorized by Region | | | |
|---------------------------------------|-----------------|-----------------|-----------------|
| Region 1 | Region 2 | Region 3 | Region 4 |
| Allegheny | Bedford | Adams | Bucks |
| Armstrong | Blair | Berks | Chester |
| Beaver | Bradford | Carbon | Delaware |
| Fayette | Butler | Cumberland | Montgomery |
| Greene | Cambria | Dauphin | Philadelphia |
| Washington | Cameron | Franklin | |
| Westmoreland | Centre | Fulton | |
| | Clarion | Huntingdon | |
| | Clearfield | Juniata | |
| | Clinton | Lancaster | |
| | Columbia | Lebanon | |
| | Crawford | Lehigh | |
| | Elk | Northampton | |
| | Erie | Perry | |
| | Forest | Schuylkill | |
| | Indiana | York | |
| | Jefferson | | |
| | Lackawanna | | |
| | Lawrence | | |
| | Luzerne | | |
| | Lycoming | | |
| | McKean | | |
| | Mercer | | |

| | | | |
|--|----------------|--|--|
| | Mifflin | | |
| | Monroe | | |
| | Montour | | |
| | Northumberland | | |
| | Pike | | |
| | Potter | | |
| | Snyder | | |
| | Somerset | | |
| | Sullivan | | |
| | Susquehanna | | |
| | Tioga | | |
| | Union | | |
| | Venango | | |
| | Warren | | |
| | Wayne | | |
| | Wyoming | | |

Appendix (D)(9)

Crosswalk

OLTL WAIVER SERVICES CROSSWALK

The new procedure codes and services names on this chart are preliminary and are contingent on CMS approval of waiver amendments

Aging Waiver

| Old Procedure Code and Service Name | New Procedure Code and Service Name |
|---|---|
| S5101-Day Care Services -Full Day S5101 32-Day Care Services -Full Day w/Bath | S5102-Adult Daily Living |
| S5102-Day Care Services-Half Day S5102 32-Day Care Services-Half Day w/Bath | S5102 U5-Adult Daily Living Services Half Day |
| W6072-Day Care Services Enhanced | S5102 U4-Adult Daily Living Services Enhanced |
| W7341-Financial Management Services | W7341-Financial Management Services |
| W7341 U4-Financial Management Services Start Up | W7341 U4-Financial Management Services Start Up |
| W7341 U2-Financial Management Services Services My Way | W7341 U2-Financial Management Services Services My Way |
| T2025-Home Health Aide | T2025-Home Health Aide |
| T2025 TE-Home Health Care LPN Services | T1003 SE-Home Health-Nursing (LPN) |
| T2025 TD-Home Health Care RN Services | T1002 SE-Home Health-Nursing (RN) |
| T2025 GO-Occupational Therapy | T2025 GO-Home Health-Occupational Therapy |
| NEW SERVICE FOR AGING | T2025 GO U4- Home Health-Occupational |

| | |
|---|--|
| | Therapy-Assist. |
| T2025 GP-Physical Therapy | T2025 GP-Home Health-Physical Therapy |
| NEW SERVICE FOR AGING | T2025 GP U4-Home Health-Physical Therapy-Assist. |
| T2025 GN-Speech Therapy | T2025 GN-Home Health-Speech&Language Therapy |
| W1700-Personal Care | W1793- PAS (Agency) |
| W1701-Personal Care Shift | |
| W1793-Personal Assistance Service (agency model) | |
| W1729-Home Support housekeeping | |
| W1792-Personal Assistance Service (combination model) | W1792-PAS (Consumer) |
| W1702-Respite Services | T1005-Respite (Agency) or S5150-Respite (Consumer) |
| W1703-Respite Shift | |
| S5151-Respite Per Diem | |
| NEW SERVICE FOR AGING | W1011-Service Coordination |
| T2025 HH-Mental Health Services | H0004-Thera&Couns Svcs (Counseling Svcs) |
| NEW SERVICE FOR AGING | S9470 AE U4-Thera&Couns Svcs (Nutritional Counseling) |
| NEW SERVICE FOR AGING | W7337-Transition Service Coordination |
| W1756-Environmental Modifications Repair | W7009-Accessibility Adaptations(<\$6000) or W7008-Accessibility Adaptations(>\$6000) |
| W1757-Environmental Modifications Adaptation | |
| W1758-Environmental Modifications Modification | |
| W7336-Community Transition Svcs (Health Safety) | W7336-Community Transition Svcs (Health Safety) |
| W7332-Community Transition Svcs (House Hold Suppl) | W7332-Community Transition Svcs (House Hold Suppl) |
| W7333-Community Transition Svcs (Moving Expenses) | W7333-Community Transition Svcs (Moving Expenses) |
| W7334-Community Transition Svcs (Security Deposit) | W7334-Community Transition Svcs (Security Deposit) |

| | |
|--|--|
| W7335-Community Transition Svcs (Set-Up Fees) | W7335-Community Transition Svcs (Set-Up Fees) |
| T2028-Specialized Medical Equipment and Supplies | T2029-Durable Medical Equipment and Supplies |
| T2029-Specialized DME | |
| W1762-Home Delivered Meals-Emergency Pack | W1762-Home Delivered Meals-Emergency Pack |
| W1760-Home Delivered Meals-Frozen Entrée | W1760-Home Delivered Meals-Frozen Entrée |
| W1759-Home Delivered Meals-Hot Entrée | W1759-Home Delivered Meals-Hot Entrée |
| W1761-Home Delivered Meals-Sandwich | W1761-Home Delivered Meals-Sandwich |
| W1764-Home Delivered Meals-Special Meal | W1764-Home Delivered Meals-Special Meal |
| W1707-Transportation one way ride | W6110-Non-medical Transportation |
| W1709-Transportation individual and escort | |
| W1712-Transportation generic | |
| W1854-Transportation attendant | |
| W1862-Transportation group | |
| W1864-Transportation group with escort | |
| W1900-Participant-Directed Community Supports | W1900-Participant-Directed Community Supports |
| W1901-Participant-Directed Goods and Services | W1901-Participant-Directed Goods and Services |
| W1718-Personal Emergency Response System (Installation) | W1894-Personal Emergency Response System (Installation) |
| W1722-PERS generic | |
| W1720-Personal Emergency Response System (Monthly Maintenance) | W1895-Personal Emergency Response System (Monthly Maintenance) |
| W2024-Telecare Equipment Installation and Removal | W2024-Telecare Equipment Installation and Removal |
| W9006-TeleCare Activity and Sensor Monitoring Ongoing | W9006-TeleCare Activity and Sensor Monitoring Ongoing |
| W2025-Telecare Equipment Installation and Removal with Training | W2025-Telecare Equipment Installation and Removal with Training |
| T2029 GT-Telecare Specialized Supplies DME for Remote Monitoring | T2029 GT-Telecare Specialized Supplies DME for Remote Monitoring |

| | |
|--|---|
| T2025 GT-Telecare Health Status Measuring and Monitoring Remote | T2025 GT-Telecare Health Status Measuring and Monitoring Remote |
| T2028 GT-Telecare Specialized Supplies for Remote Monitoring | T2028 GT-Telecare Specialized Supplies for Remote Monitoring |
| S5185 32-TeleCare Medication Dispensing and Monitoring | S5185 32-TeleCare Medication Dispensing and Monitoring |
| W1723-Companion Services W1732-Initial Extermination W1733-Follow-up Extermination | Services/Codes no longer available |
| No change to this existing service | |
| Change in Procedure Code/Name | |

OLTL WAIVER SERVICES CROSSWALK
The new procedure codes and services names on this chart are preliminary and are contingent on CMS approval of waiver amendments

Attendant Care Waiver

| Old Procedure Code and Service Name | New Procedure Code and Service Name |
|--|--|
| W7341-Financial Management Services | W7341-Financial Management Services |
| W7341 U4-Financial Management Services Start Up | W7341 U4-Financial Management Services Start Up |
| W7341 U2-Financial Management Services Services My Way | W7341 U2-Financial Management Services Services My Way |
| W1793- PAS (Agency) | W1793- PAS (Agency) |
| W1792-PAS (Consumer) | W1792-PAS (Consumer) |
| W1794-Service Coordination | W1011-Service Coordination |
| W7337-Transition Svc Coordination | W7337-Transition Svc Coordination |
| W7336-Community Transition Svcs (Health Safety) | W7336-Community Transition Svcs (Health Safety) |

| | |
|--|--|
| W7332-Community Transition Svcs (House Hold Suppl) | W7332-Community Transition Svcs (House Hold Suppl) |
| W7333-Community Transition Svcs (Moving Expenses) | W7333-Community Transition Svcs (Moving Expenses) |
| W7334-Community Transition Svcs (Security Deposit) | W7334-Community Transition Svcs (Security Deposit) |
| W7335-Community Transition Svcs (Set-Up Fees) | W7335-Community Transition Svcs (Set-Up Fees) |
| W1900-Participant-Directed Community Supports | W1900-Participant-Directed Community Supports |
| W1901-Participant-Directed Goods and Services | W1901-Participant-Directed Goods and Services |
| W1894-Personal Emergency Response System (Installation) | W1894-Personal Emergency Response System (Installation) |
| W1895-Personal Emergency Response System (Monthly Maintenance) | W1895-Personal Emergency Response System (Monthly Maintenance) |
| W7340-Intake Supports Coordination | Services/Codes no longer available |
| No change to this existing service | |
| Change in Procedure Code/Name | |

OLTL WAIVER SERVICES CROSSWALK
The new procedure codes and services names on this chart are preliminary and are contingent on CMS approval of waiver amendments

Act 150 Program

| Old Procedure Code and Service Name | New Procedure Code and Service Name |
|---|---|
| W7341-Financial Management Services | W7341-Financial Management Services |
| W7341 U4-Financial Management Services Start Up | W7341 U4-Financial Management Services Start Up |
| W7341 U2-Financial Management Services | W7341 U2-Financial Management Services |

| | |
|--|--|
| Services My Way | Services My Way |
| W1793- PAS (Agency) | W1793- PAS (Agency) |
| W1792-PAS (Consumer) | W1792-PAS (Consumer) |
| W1794-Service Coordination | W1011-Service Coordination |
| W1894-Personal Emergency Response System (Installation) | W1894-Personal Emergency Response System (Installation) |
| W1895-Personal Emergency Response System (Monthly Maintenance) | W1895-Personal Emergency Response System (Monthly Maintenance) |
| W7340-Intake Supports Coordination | Services/Codes no longer available |
| No change to this existing service | |
| Change in Procedure Code/Name | |

OLTL WAIVER SERVICES CROSSWALK
The new procedure codes and services names on this chart are preliminary and are contingent on CMS approval of waiver amendments

COMM CARE Waiver

| Old Procedure Code and Service Name | New Procedure Code and Service Name |
|---|---|
| S5102-Adult Daily Living | S5102-Adult Daily Living |
| NEW SERVICE FOR COMM CARE | S5102 U4-Adult Daily Living Services Enhanced |
| NEW SERVICE FOR COMM CARE | S5102 U5-Adult Daily Living Services Half Day |
| 97537-Community Integration | 97537-Community Integration |
| W7341-Financial Management Services | W7341-Financial Management Services |
| W7341 U4-Financial Management Services Start Up | W7341 U4-Financial Management Services Start Up |

| | |
|--|--|
| W7341 U2-Financial Management Services Services My Way | W7341 U2-Financial Management Services Services My Way |
| T1002 SE-Home Health-Nursing (RN) | T1002 SE-Home Health-Nursing (RN) |
| T1003 SE-Home Health-Nursing (LPN) | T1003 SE-Home Health-Nursing (LPN) |
| T2025 GO-Home Health-Occupational Therapy | T2025 GO-Home Health-Occupational Therapy |
| NEW SERVICE FOR COMMCARE | T2025 GO U4- Home Health-Occupational Therapy-Assist. |
| T2025 GP-Home Health-Physical Therapy | T2025 GP-Home Health-Physical Therapy |
| NEW SERVICE FOR COMMCARE | T2025 GP U4-Home Health-Physical Therapy-Assist. |
| T2025 GN-Home Health-Speech&Language Therapy | T2025 GN-Home Health-Speech&Language Therapy |
| W1793-PAS (Agency) | W1793-PAS (Agency) |
| S5120-PAS (Chore Svcs) | |
| W6043 UJ-PAS (Night Supervision, Agency, Weekdays) | |
| W6043 TV-PAS (Night Supervision, Agency, Weekends) | |
| W1792-PAS (Consumer) | W1792-PAS (Consumer) |
| W6042 UJ-PAS (Night Supervision, Consumer, Weekdays) | |
| W6042 TV-PAS (Night Supervision, Consumer, Weekends) | |
| W6107-Prevocational Services | W6107-Prevocational Services |
| W0100-Residential Habilitation 1-3 Setting | W0100- Residential Habilitation 1-3 Setting |
| W0101 U4-Residential Habilitation 1-3 Supp 1:1 | W0101 U4-Residential Habilitation 1-3 Supp 1:1 |
| W0101 U5-Residential Habilitation 1-3 Supp 2:1 | W0101 U5-Residential Habilitation 1-3 Supp 2:1 |
| W0102-Residential Habilitation 4-8 Setting | W0102-Residential Habilitation 4-8 Setting |
| W0103 U4-Residential Habilitation 4-8 Supp 1:1 | W0103 U4-Residential Habilitation 4-8 Supp 1:1 |
| W0103 U5-Residential Habilitation 4-8 Supp 2:1 | W0103 U5-Residential Habilitation 4-8 Supp 2:1 |

| | |
|---|---|
| T1005-Respite (Agency) | T1005-Respite (Agency) |
| S5150-Respite (Consumer) | S5150-Respite (Consumer) |
| W1877-Service Coordination | W1011-Service Coordination |
| W0104-Structured Day Habilitation Group | W0104-Structured Day Habilitation Group |
| W0105 U4-Structured Day Habilitation 1:1 | W0105 U4-Structured Day Habilitation 1:1 |
| W0105 U5-Structured Day Habilitation 2:1 | W0105 U5-Structured Day Habilitation 2:1 |
| W6106-Supported Employment | W6106-Supported Employment |
| T2025 HH-Behavioral Health Counseling/Therapy H0032 SE-Behavioral Specialist Consultant 97533 SE-Behavioral Therapy, Coach (Agency) | H2019-Thera&Couns Svcs (Behavior Therapy) |
| 97532 SE-Thera&Couns Svcs (Cognitive Rehabilitation) | 97532 SE-Thera&Couns Svcs (Cognitive Rehabilitation) |
| NEW SERVICE FOR COMMCARE | H0004-Thera&Couns Svcs (Counseling Svcs) |
| NEW SERVICE FOR COMMCARE | S9470 AE U4-Thera&Couns Svcs (Nutritional Counseling) |
| W7337-Transition Service Coordination | W7337-Transition Service Coordination |
| W7008-AccessAdapt, Equip, Tech&MedSuppl(EnvMods<\$100) | W7008-Accessibility Adaptations(<\$6000) |
| W7009-AccessAdapt, Equip, Tech&MedSuppl(EnvMods>\$100) | W7009-Accessibility Adaptations(>\$6000) |
| W7336-Community Transition Svcs (Health Safety) | W7336-Community Transition Svcs (Health Safety) |
| W7332-Community Transition Svcs (House Hold Suppl) | W7332-Community Transition Svcs (House Hold Suppl) |
| W7333-Community Transition Svcs (Moving Expenses) | W7333-Community Transition Svcs (Moving Expenses) |
| W7334-Community Transition Svcs (Security Deposit) | W7334-Community Transition Svcs (Security Deposit) |
| W7335-Community Transition Svcs (Set-Up) | W7335-Community Transition Svcs (Set-Up) |

| | |
|--|--|
| Fees) | Fees) |
| T2029-Access Adapt, Equip, Tech&Med Suppl (DME, AT) | T2029-Durable Medical Equipment and Supplies |
| W6110-Non-medical Transportation | W6110-Non-medical Transportation |
| W1894-Personal Emergency Response System (Installation) | W1894-Personal Emergency Response System (Installation) |
| W1895-Personal Emergency Response System (Monthly Maintenance) | W1895-Personal Emergency Response System (Monthly Maintenance) |
| W7340-Intake Supports Coordination H2019 SE-Behavioral Therapy, Coach (Consumer) W6105-Education Svcs T2038-Community Transition Svcs | Services/Codes no longer available |
| No change to this existing service | |
| Change in Procedure Code/Name | |

OLTL WAIVER SERVICES CROSSWALK
The new procedure codes and services names on this chart are preliminary and are contingent on CMS approval of waiver amendments

Independence Waiver

| Old Procedure Code and Service Name | New Procedure Code and Service Name |
|---|---|
| S5102-Adult Daily Living | S5102-Adult Daily Living |
| NEW SERVICE FOR Independence | S5102 U4-Adult Daily Living Services Enhanced |
| NEW SERVICE FOR Independence | S5102 U5-Adult Daily Living Services Half Day |
| 97537-Community Integration 97537 TF-Community Integration (Peer Counselor) 97537 TG-Community Integration (Skills Trainer) | 97537-Community Integration |

| | |
|--|--|
| W7341-Financial Management Services | W7341-Financial Management Services |
| W7341 U4-Financial Management Services Start Up | W7341 U4-Financial Management Services Start Up |
| W7341 U2-Financial Management Services Services My Way | W7341 U2-Financial Management Services Services My Way |
| T1002 SE-Home Health-Nursing (RN) | T1002 SE-Home Health-Nursing (RN) |
| T1003 SE-Home Health-Nursing (LPN) | T1003 SE-Home Health-Nursing (LPN) |
| T2025 GO-Home Health-Occupational Therapy | T2025 GO-Home Health-Occupational Therapy |
| NEW SERVICE FOR Independence | T2025 GO U4- Home Health-Occupational Therapy-Assist. |
| T2025 GP-Home Health-Physical Therapy | T2025 GP-Home Health-Physical Therapy |
| NEW SERVICE FOR Independence | T2025 GP U4-Home Health-Physical Therapy-Assist. |
| T2025 GN-Home Health-Speech&Language Therapy | T2025 GN-Home Health-Speech&Language Therapy |
| W1793-PAS (Agency) | W1793-PAS (Agency) |
| W1792-PAS (Consumer) | W1792-PAS (Consumer) |
| W1793 TT-PAS (CSLA) | W1793 TT-PAS (CSLA) |
| T1005-Respite (Agency) | T1005-Respite (Agency) |
| S5150-Respite (Consumer) | S5150-Respite (Consumer) |
| W1877-Service Coordination | W1011-Service Coordination |
| W6106-Supported Employment | W6106-Supported Employment |
| T2025 HH-Thera&Couns Svcs (Behavior Therapy) | H2019-Thera&Couns Svcs (Behavior Therapy) |
| NEW SERVICE FOR Independence | 97532 SE-Thera&Couns Svcs (Cognitive Rehabilitation) |
| NEW SERVICE FOR Independence | H0004-Thera&Couns Svcs (Counseling Svcs) |
| NEW SERVICE FOR Independence | S9470 AE U4-Thera&Couns Svcs (Nutritional Counseling) |

| | |
|---|--|
| W7337-Transition Service Coordination | W7337-Transition Service Coordination |
| W7008-AccessAdapt, Equip, Tech&MedSuppl(EnvMods<\$100) | W7008-Accessibility Adaptations(<\$6000) |
| W7009-AccessAdapt, Equip, Tech&MedSuppl(EnvMods>\$100) | W7009-Accessibility Adaptations(>\$6000) |
| W7336-Community Transition Svcs (Health Safety) | W7336-Community Transition Svcs (Health Safety) |
| W7332-Community Transition Svcs (House Hold Suppl) | W7332-Community Transition Svcs (House Hold Suppl) |
| W7333-Community Transition Svcs (Moving Expenses) | W7333-Community Transition Svcs (Moving Expenses) |
| W7334-Community Transition Svcs (Security Deposit) | W7334-Community Transition Svcs (Security Deposit) |
| W7335-Community Transition Svcs (Set-Up Fees) | W7335-Community Transition Svcs (Set-Up Fees) |
| T2029-Access Adapt, Equip, Tech&Med Suppl (DME, AT) | T2029-Durable Medical Equipment and Supplies |
| W6110-Non-medical Transportation | W6110-Non-medical Transportation |
| W1894-Personal Emergency Response System (Installation) | W1894-Personal Emergency Response System (Installation) |
| W1895-Personal Emergency Response System (Monthly Maintenance) | W1895-Personal Emergency Response System (Monthly Maintenance) |
| W7033-Non-Medical Transportation (Additional) W7340-Intake Supports Coordination W6105-Education Svcs T2038-Community Transition Svcs T1005 TT-Respite (CSLA) | Services/Codes no longer available |
| No change to this existing service | |
| Change in Procedure Code/Name | |

OLTL WAIVER SERVICES CROSSWALK
The new procedure codes and services names on this chart are preliminary and are contingent on CMS approval of waiver amendments

OBRA Waiver

| Old Procedure Code and Service Name | New Procedure Code and Service Name |
|---|--|
| S5102-Adult Daily Living | S5102-Adult Daily Living |
| NEW SERVICE FOR OBRA | S5102 U4-Adult Daily Living Services Enhanced |
| NEW SERVICE FOR OBRA | S5102 U5-Adult Daily Living Services Half Day |
| 97537-Community Integration 97537 TF-Community Integration (Peer Counselor) 97537 TG-Community Integration (Skills Trainer) | 97537-Community Integration |
| W7341-Financial Management Services | W7341-Financial Management Services |
| W7341 U4-Financial Management Services Start Up | W7341 U4-Financial Management Services Start Up |
| W7341 U2-Financial Management Services Services My Way | W7341 U2-Financial Management Services Services My Way |
| T1002 SE-Home Health-Nursing (RN) | T1002 SE-Home Health-Nursing (RN) |
| T1003 SE-Home Health-Nursing (LPN) | T1003 SE-Home Health-Nursing (LPN) |
| T2025 GO-Home Health-Occupational Therapy | T2025 GO-Home Health-Occupational Therapy |
| NEW SERVICE FOR OBRA | T2025 GO U4- Home Health-Occupational Therapy-Assist. |
| T2025 GP-Home Health-Physical Therapy | T2025 GP-Home Health-Physical Therapy |
| NEW SERVICE FOR OBRA | T2025 GP U4-Home Health-Physical Therapy-Assist. |
| T2025 GN-Home Health-Speech&Language Therapy | T2025 GN-Home Health-Speech&Language Therapy |
| W1793-PAS (Agency) | W1793-PAS (Agency) |
| W1792-PAS (Consumer) | W1792-PAS (Consumer) |
| W1793 TT-PAS (CSLA) | W1793 TT-PAS (CSLA) |

| | |
|---|--|
| T1005-Respite (Agency) | T1005-Respite (Agency) |
| S5150-Respite (Consumer) | S5150-Respite (Consumer) |
| W6107-Prevocational Services | W6107-Prevocational Services |
| W0100-Residential Habilitation 1-3 Setting | W0100- Residential Habilitation 1-3 Setting |
| W0101 U4-Residential Habilitation 1-3 Supp 1:1 | W0101 U4-Residential Habilitation 1-3 Supp 1:1 |
| W0101 U5-Residential Habilitation 1-3 Supp 2:1 | W0101 U5-Residential Habilitation 1-3 Supp 2:1 |
| W0102-Residential Habilitation 4-8 Setting | W0102-Residential Habilitation 4-8 Setting |
| W0103 U4-Residential Habilitation 4-8 Supp 1:1 | W0103 U4-Residential Habilitation 4-8 Supp 1:1 |
| W0103 U5-Residential Habilitation 4-8 Supp 2:1 | W0103 U5-Residential Habilitation 4-8 Supp 2:1 |
| T1005-Respite (Agency) | T1005-Respite (Agency) |
| S5150-Respite (Consumer) | S5150-Respite (Consumer) |
| W6100-Service Coordination | W1011-Service Coordination |
| W0104-Structured Day Habilitation Group | W0104-Structured Day Habilitation Group |
| W0105 U4-Structured Day Habilitation 1:1 | W0105 U4-Structured Day Habilitation 1:1 |
| W0105 U5-Structured Day Habilitation 2:1 | W0105 U5-Structured Day Habilitation 2:1 |
| W6106-Supported Employment | W6106-Supported Employment |
| T2025 HH-Behavioral Therapy H0002-Behavioral Therapy, Assessment 97533 SE-Behavioral Therapy, Coach | H2019-Thera&Couns Svcs (Behavior Therapy) |
| NEW SERVICE FOR OBRA | 97532 SE-Thera&Couns Svcs (Cognitive Rehabilitation) |
| NEW SERVICE FOR OBRA | H0004-Thera&Couns Svcs (Counseling Svcs) |
| NEW SERVICE FOR OBRA | S9470 AE U4-Thera&Couns Svcs (Nutritional Counseling) |
| W7337-Transition Service Coordination | W7337-Transition Service Coordination |

| | |
|--|--|
| W7008-AccessAdapt, Equip, Tech&MedSuppl(EnvMods<\$100) | W7008-Accessibility Adaptations(<\$6000) |
| W7009-AccessAdapt, Equip, Tech&MedSuppl(EnvMods>\$100) | W7009-Accessibility Adaptations(>\$6000) |
| W7336-Community Transition Svcs (Health Safety) | W7336-Community Transition Svcs (Health Safety) |
| W7332-Community Transition Svcs (House Hold Suppl) | W7332-Community Transition Svcs (House Hold Suppl) |
| W7333-Community Transition Svcs (Moving Expenses) | W7333-Community Transition Svcs (Moving Expenses) |
| W7334-Community Transition Svcs (Security Deposit) | W7334-Community Transition Svcs (Security Deposit) |
| W7335-Community Transition Svcs (Set-Up Fees) | W7335-Community Transition Svcs (Set-Up Fees) |
| T2029-Access Adapt, Equip, Tech&Med Suppl (DME, AT) | T2029-Durable Medical Equipment and Supplies |
| W6110-Non-medical Transportation | W6110-Non-medical Transportation |
| W1894-Personal Emergency Response System (Installation) | W1894-Personal Emergency Response System (Installation) |
| W1895-Personal Emergency Response System (Monthly Maintenance) | W1895-Personal Emergency Response System (Monthly Maintenance) |
| W7340-Intake Supports Coordination H2019 SE-Behavioral Therapy, Coach (Consumer) W6105-Education Svcs T2038-Community Transition Svcs T1005 TT-Respite (CSLA) W7033-Non-Medical Transportation (Additional) | Services/Codes no longer available |
| No change to this existing service | |
| Change in Procedure Code/Name | |

Appendix (D)(10)

Remittance Advice Sample

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF PUBLIC WELFARE
 PA PROMISe
 PROVIDER REMITTANCE ADVICE

Processing Date: 02/22/2008

Page: 000,000

0

| PROVIDER NUMBER 000000000 | LOC 0000 | TYPE 00 | NPI NUMBER 000000000 | | | AMOUNT BILLED | AMOUNT PAID | STATUS | EXPLANATION CODES OR COMMENTS |
|------------------------------|----------------|------------|-------------------------------|------------------------|--|----------------------------|----------------|--------|----------------------------------|
| ICN | LINE NUMBER | QTY | BEGIN DATE OF SERVICE | END DATE OF SERVICE | PROCEDURE CODE MODIFIER or DRUG ID | | | | |
| RID: 000000000 | | | RECIPIENT NAME: LAST, FIRST A | | | | | | |
| 27000000000001 | 0 | | | | | 125.72 | 122.72 | P | |
| 27000000000001 | 1 | 29 | 01/07/2008 | 01/13/2008 | | 125.72 | 122.72 | P | 9001 |
| COPAY: 3.00 | | | DATE OF CLAIM: 01/18/2008 | | | TOTAL CLAIM BILLED: 125.72 | | | |
| PATIENT ACCT NBR: ACCT001 | | | | | | | | | |
| RID: 000000000 | | | RECIPIENT NAME: LAST, FIRST B | | | | | | |
| 27000000000003 | 0 | | | | | 135.80 | 00.00 | D | 226 |
| 27000000000003 | 1 | 12 | 01/07/2008 | 01/10/2008 | | 135.80 | 00.00 | D | 223 |
| COPAY: 0.00 | | | DATE OF CLAIM: 01/18/2008 | | | TOTAL CLAIM BILLED: 135.80 | | | |
| PATIENT ACCT NBR: ACCT002 | | | | | | | | | |
| 69000000000003 | 0 | | | | | 120.00 | 120.00 | P | |
| 69000000000003 | 1 | 12 | 01/07/2008 | 01/10/2008 | | 120.00 | 120.00 | P | 2700000000003 /0000 |
| COPAY: 0.00 | | | DATE OF CLAIM: 01/19/2008 | | | TOTAL CLAIM BILLED: 120.00 | | | |
| PATIENT ACCT NBR: ACCT002 | | | | | | | | | |
| RID: 000000000 | | | RECIPIENT NAME: LAST, FIRST C | | | | | | |
| 27000000000004 | 0 | | | | | 124.00 | 90.00 | P | |
| 27000000000004 | 1 | 1 | 01/02/2008 | 01/02/2008 | | 31.00 | 00.00 | D | 234 |
| 27000000000004 | 2 | 3 | 01/02/2008 | 01/02/2008 | W0000 | 93.00 | 90.00 | P | 9000 |
| COPAY: 0.00 | | | DATE OF CLAIM: 01/19/2008 | | | TOTAL CLAIM BILLED: 124.00 | | | |
| PATIENT ACCT NBR: ACCT003 | | | | | | | | | |
| 69000000000005 | 0 | | | | | 161.00 | 161.00 | P | |
| 69000000000005 | 1 | 1 | 12/02/2008 | 01/02/2008 | 00001 | 49.00 | 49.00 | P | |
| 69000000000005 | 2 | 3 | 12/02/2008 | 01/02/2008 | 00002 | 112.00 | 112.00 | P | 2700000000000 /0000 |
| COPAY: 0.00 | | | DATE OF CLAIM: 01/19/2008 | | | TOTAL CLAIM BILLED: 161.00 | | | |
| PATIENT ACCT NBR: ACCT003 | | | | | | | | | |
| RA NUMBER 00/000000 | | | | | | | | | |

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF PUBLIC WELFARE
 PA PROMIS_e
 PROVIDER REMITTANCE ADVICE

Processing Date: 02/22/2008

Page: 000,000

0

PROVIDER NUMBER 000000000
 LOC 0000
 TYPE 00
 NPI NUMBER 0000000000

| SUMMARY | -----NUMBER----- | | | | -----AMOUNT----- | |
|--------------------------|------------------|--------|-----------|----------|------------------|----------|
| | PROCESSED | DENIED | SUSPENDED | APPROVED | BILLED | PAID |
| CLAIM / ADJUSTMENTS | 24 | 3 | 2 | 19 | 2,294.56 | 1,889.28 |
| CLAIM DETAILS | 36 | 6 | 4 | 26 | 2,294.56 | 1,889.28 |
| ADJUSTMENT DETAILS | 2 | 0 | 0 | 2 | 92.50 | 92.50 |
| SYSGEN CLAIM ADJ DETAILS | 0 | 0 | 0 | 0 | 00.00 | 00.00 |
| CREDITS | 1 | 0 | 0 | 1 | 00.00 | 90.00 CR |
| NET GROSS ADJUSTMENTS | 0 | | | 0 | 00.00 | 00.00 |
| LIEN PAYMENT | 1 | | | 1 | 25.00 | 25.00 |
| BEGINNING CREDIT BALANCE | | | | | | 50.00 |
| PAYMENT AMOUNT | | | | | | 1816.78 |
| COPAY DEDUCTED | | | | | | 0.00 |
| GA DEDUCTIBLE | | | | | | 0.00 |
| UPDATE TO CR BALANCE | | | | | | 0.00 |
| NEW CREDIT BALANCE | | | | | | 0.00 |
| BEGINNING YTD BALANCE | | | | | | 6783.91 |
| NEW YTD BALANCE | | | | | | 8600.69 |

PROVIDER NAME
 STREET ADDRESS
 CITY, ST ZIP00-0000

RA NUMBER 00 / 00000
 VT/ITEM NUMBER 00000000 / 000000

Appendix (E)

Glossary

ADL—Activities of daily living—The term includes eating, drinking, ambulating, transferring in and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, self-administering medication and proper turning and positioning in a bed or chair.

Act 150—A State-funded program under the Attendant Care Services Act (62 P. S. §§ 3051—3058).

Aging waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act (42 U.S.C.A § 1396n(c)) that authorizes services to participants 60 years of age or older.

Applicant—An individual or legal entity in the process of enrolling as a provider.

Attendant Care waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act that authorizes services to participants 18 years of age or older but under 60 years of age with physical disabilities.

Attestation engagement—Financial services that result in the issuance of a report on a subject matter or an assertion about the subject matter that is the responsibility of another party. The term includes audits, examinations, reviews, compilations and agreed-upon procedures.

Back-up plan—A component of the service plan that is comprised of the individualized back-up plan and the emergency back-up plan.

CAP—Corrective action plan—A plan created by the provider or the Department to address provider noncompliance with this chapter.

CHAMPUS—Civilian Health and Medical Program of Uniformed Services.

COMM CARE—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act called the Community Care waiver that authorizes services to participants 21 years of age and older with traumatic brain injuries.

Community transition service—A one-time service which assists a participant to move from an institution to the participant's home, apartment or another noninstitutional living arrangement.

Community transition service provider—A provider who renders community transition services.

Complaint—Dissatisfaction with program operations, activities or services received, or not received, involving HCBS.

Critical incident—An occurrence of an event that jeopardizes the participant’s health or welfare including:

(i) Death, serious injury or hospitalization of a participant. Pre-planned hospitalizations are not critical incidents.

(ii) Provider and staff member misconduct including deliberate, willful, unlawful or dishonest activities.

(iii) Abuse, including the infliction of injury, unreasonable confinement, intimidation, punishment or mental anguish, of the participant. Abuse includes the following:

(A) Physical abuse.

(B) Psychological abuse.

(C) Sexual abuse.

(D) Verbal abuse.

(iv) Neglect.

(v) Exploitation.

(vi) Service interruption, which is an event that results in the participant’s inability to receive services and that places the participant’s health or welfare at risk.

(vii) Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Department—the Department of Public Welfare of the Commonwealth.

Direct care worker—A person employed for compensation by a provider or participant who provides personal assistance services or respite services.

EPLS—Excluded Parties List System—A database maintained by the United States General Services Administration that provides information about parties that are excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and nonfinancial assistance and benefits.

Emergency back-up plan—A plan which outlines the steps to be taken by the provider and the participant to ensure that the participant’s needs are met in an emergency.

Fee schedule service—A service paid based on the MA Program fee schedule rates established by the Department.

Financial management services—A service which provides payroll, invoice processing and payment, fiscal reporting services, employer orientation, skills training and other fiscal-related services to participants choosing to exercise employer or participant-directed budget authority.

Financial review—A review of billing records against provider documentation to ensure services were provided in the type, scope, amount, duration and frequency as required by the participant's service plan and to ensure that a billing for a service rendered by a provider is accurate.

Finding—An identified violation of the following:

- (i) This chapter.
- (ii) The MA provider agreement, including the waiver addendum.
- (iii) Chapter 1101 (relating to general provisions).
- (iv) The approved applicable waiver, including approved waiver amendments.
- (v) A State or Federal requirement.

HCBS—Home and community-based services—Services offered as part of a Federally-approved MA waiver or Act 150 program.

IADL—Instrumental activities of daily living—The term includes the following activities when done on behalf of a participant:

- (i) Laundry.
- (ii) Shopping.
- (iii) Securing and using transportation.
- (iv) Using a telephone.
- (v) Making and keeping appointments.
- (vi) Caring for personal possessions.
- (vii) Writing correspondence.
- (viii) Using a prosthetic device.

(ix) Housekeeping.

ICF/ORC—Intermediate care facility/other related conditions.

Independence waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act that authorizes services to participants 18 years of age and older but under 60 years of age with physical disabilities.

Individualized back-up plan—A plan which outlines the steps to be taken by the provider and participant to ensure that services are delivered to the participant in a situation where routine service delivery is interrupted.

Informal community supports—Services provided by a family member, friend, community organization or other entity for which funding is not provided by the Department.

LEIE—*List of Excluded Individuals and Entities*—A database maintained by the United States Department of Health and Human Services, Office of the Inspector General, that identifies individuals or entities that have been excluded Nationwide from participation in a Federal health care program.

Level of care re-evaluation—A redetermination of a participant's clinical eligibility under a waiver or the Act 150 program.

MA—Medical Assistance.

MA provider agreement—An enrollment agreement signed by the provider which establishes requirements relating to the provision of services.

Medicaid—MA provided under a State Plan approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act (42 U.S.C.A. § 1396a).

Medicaid State Plan—A plan to provide MA developed by the Department and approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act which serves as the basis for Federal financial participation in the program.

Medicheck—A Departmental list identifying providers, individuals and other entities precluded from participation in the Commonwealth's MA Program.

Monitoring—A review of a provider's compliance.

Nursing facility—

- (i) A long-term care facility that is:
 - (A) Licensed by the Department of Health.

(B) Enrolled in the MA Program as a provider of nursing facility services.

(C) Owned by a person, partnership, association or corporation and operated on a profit or nonprofit basis.

(ii) The term does not include the following:

(A) Intermediate care facilities for individuals with developmental or intellectual disabilities or other related conditions

(B) Federal or State-owned long-term care nursing facilities.

OBRA waiver—A Federally-approved 1915(c) waiver under section 1915(c) of the Social Security Act named for the Omnibus Budget and Reconciliation Act of 1981 (Pub. L. No. 97-35) that authorizes services to participants 18 years of age or older but under 60 years of age with developmental disabilities.

OHCDs—Organized Health Care Delivery System provider—A provider who is authorized by the Department to contract with an entity to provide a vendor good or service.

Participant—A person receiving services through a waiver or the Act 150 program.

Participant-directed budget authority—The spending authority granted to the participant through a waiver whereby the participant is authorized to spend the amount of money allocated in the participant's service plan on goods and services.

Participant goal—A service plan requirement that states a participant's objective towards obtaining or maintaining independence in the community.

Participant need—A service plan requirement based on a person-centered assessment.

Participant outcome—A service plan requirement that measures whether a service, TPR or informal community support is achieving a participant goal.

Person-centered approach—A holistic approach to serving participants which focuses on a participant's individual and specific strengths, interests and needs.

Person-centered assessment—A Department-approved questionnaire used to determine the specific needs of a participant by utilizing a person-centered approach.

Personal assistance services—Services aimed at assisting the participant to complete ADLs and IADLs that would be performed independently if the participant did not have a disability.

Preventable incident—A critical incident that could be avoided through appropriate training of a staff member or participant following established policies and procedures or implementation of other reasonable precautionary measures.

Provider—A Department-enrolled entity which provides a service.

QMP—Quality Management Plan—A provider-created plan to address areas of quality improvement identified by the provider or the Department.

Respite services—Personal assistance services which are provided on a temporary, short-term basis when a noncompensated caregiver is unavailable to provide personal assistance services.

Risk mitigation strategies—Methods to reduce risks to a participant's health and safety.

SCE—Service coordination entity—A provider authorized to render service coordination services in a waiver or Act 150 program.

Service—A benefit which a participant receives under an approved MA waiver or the Act 150 program.

Service coordination—Service that assists a participant in gaining access to needed waiver services, MA State Plan services and other medical, social and educational services regardless of funding source.

Service coordinator—A staff member who provides service coordination services at an SCE.

Service plan—The Department-approved comprehensive written summary of a participant's services, TPR and informal community supports.

TPR—Third party medical resource—Medical resources used to pay for participant services, including Medicare, CHAMPUS, workers' compensation, for profit and nonprofit health care coverage and insurance policies, and other forms of insurances.

Vendor good or service—A rendered item or service that is not on the MA fee schedule for which the Department reimburses an OHCDS or provider.

Waiver—The Aging, Attendant Care, COMMCARE, Independence, and OBRA Home and Community-Based Service waivers approved by the Federal Centers for Medicare and Medicaid Services.

Reference: 55 Pa. Code Chapter 52

Appendix (F)

Acronym List

| | |
|-----------------|---|
| AAA | Area Agency on Aging |
| ACN | Attachment Control Number |
| ADL | Activity of Daily Living |
| BPI | Bureau of Program Integrity |
| CAO | County Assistance Office |
| CIS | Client Information System |
| CMS | Centers for Medicare and Medicaid Services |
| COMMCARE | Community Care Waiver |
| DCW | Direct Care Worker |
| DME | Durable Medical Equipment |
| DPPC | Division of Program and Provider Compliance |
| DPR | Division of Provider Review |
| DPW | Department of Public Welfare |
| EIM | Enterprise Incident Management |
| EVS | Eligibility Verification System |
| FFS | Fee-For-Service |
| FMS | Financial Management Services |
| HCBS | Home and Community-Based Services |
| HCSIS | Home and Community Services Information System |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HIPP | Health Insurance Premium Payment |
| IEB | Independent Enrollment Broker |
| ICF | Intermediate Care Facility |
| ISP | Individual Service Plan |
| LEIE | List of Excluded Individuals/Entities |
| LEP | Limited English Proficiency |
| LIFE | Living Independence for the Elderly |
| LOCA | Level of Care Assessment (tool) |
| MA | Medical Assistance, Medicaid |
| MCO | Managed Care Organization |
| MFP | Money Follows the Person |
| NF | Nursing Facility |
| NHT | Nursing Home Transition |
| OBRA | Omnibus Budget Reconciliation Act |
| OHCDs | Organized Health Care Delivery System |
| OLTL | Office of Long-Term Living |
| PACE | Program of All-Inclusive Care for the Elderly |
| PASA | Provider Access to Service Authorizations |
| PERS | Personal Emergency Response System |
| PROMISe | Provider Reimbursement and Operations Management Information System |
| QMET | Quality Management Efficiency Team |

| | |
|--------------|-------------------------------------|
| QPM | Quality and Provider Management |
| RA | Remittance Advice |
| RFA | Request for Application |
| SAMS | Social Assistance Management System |
| SCE | Service Coordination Entity |
| SMW | Services My Way |
| TBI | Traumatic Brain Injury |
| TPL | Third Party Liability (Division) |
| VF/EA | Vendor Fiscal/Employer Agent |