
2019
List of Appendices to EPSDT Support Coordination Handbook

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Revised 3.13.19
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**Developmental Disability (DD) Medicaid Waiver Services**

The following services are available to children and youth with developmental disabilities. To request them call the Office for Citizens with Developmental Disabilities (OCDD) District and Authority in your area. Phone numbers are listed on the attachment.

To sign up for "waiver programs" that offer Medicaid and additional services to eligible persons (including those whose income may be too high for other Medicaid), ask to be added to the Developmental Disabilities Request for Services Registry (DD RFSR) for people with developmental disabilities.

The **New Opportunities Waiver (NOW)** and the **Children’s Choice Waiver** both provide services in the home, instead of in an institution, to persons who have intellectual disabilities and/or other developmental disabilities. Both waivers cover family support, center-based respite, environmental accessibility modifications, and specialized medical equipment and supplies. In addition, **NOW** covers services to help individuals live alone in the community or to assist with employment, and professional and nursing services beyond those that Medicaid usually covers. The **NOW** is only available to individuals who cannot be supported in another OCDD waiver (Children’s Choice, Supports Waiver, or Residential Options Waiver).

The **Children’s Choice Waiver** also includes family training. Children remain eligible for the Children’s Choice Waiver until their twenty-first birthday, at which time they are moved to an age-appropriate waiver for people with developmental disabilities.

The **Supports Waiver** provides specific, activity focused services rather than continuous custodial care. This waiver offers supported employment, day habilitation, prevocational services, respite, habilitation, permanent supportive housing stabilization, permanent supportive housing stabilization transition, and personal emergency response systems for individuals age 18 and older.

The **Residential Options Waiver (ROW)** is appropriate for those individuals whose health and welfare can be assured by the support plan with a cost limit based on their level of support need. This waiver offers community living supports, companion care, host home, shared living, one-time transitional services, environmental modifications, assistive technology/specialized medical equipment, personal emergency response systems, respite (center-based), nursing, dental, professional (dietary, speech therapy, occupational therapy, physical therapy, social work, psychology), transportation–community access, supported employment, prevocational services, day habilitation, housing stabilization, housing stabilization transition services, and adult day health care (ADHC).

**If you need services for someone 0 to 3 years old, please contact EarlySteps by calling 1-866-327-5978.**
Support Coordination
A support coordinator works with you to develop a full list of all the services you need and then helps you get them. This can include things like medical care, therapies, personal care services, equipment, social services, and educational services. **If you are a Medicaid recipient and under the age of 21 and it is medically necessary, you may be eligible to receive support coordination services immediately.** Contact Statistical Resources, Inc. (SRI) at 1-800-364-7828.

The following benefits are available to all Medicaid eligible children and youth under the age of 21 who have a medical need:

Transportation
Non-Emergency Transportation to and from medical appointments, if needed, is covered under the Medicaid Managed Care Program. Medicaid recipients that do not get their full coverage through the Medicaid Managed Care Program will still get transportation coverage through their Managed Care Organization. Arrangements for transportation should always be made at least 48 hours in advance by calling the numbers shown below.

- **Aetna Better Health** 1-877-917-4150
- **AmeriHealth Caritas Louisiana** 1-888-913-0364
- **Healthy Blue** 1-866-430-1101
- **Louisiana Healthcare Connections** 1-866-369-3723
- **United Healthcare Community Plan** 1-866-726-1472

If you are not sure who your Managed Care Organization is you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out which Managed Care Organization you are covered under.

Applied Behavioral Analysis- Based Therapy Services (ABA)
ABA therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence of their success in alleviating autism and are not experimental. This service is available through Medicaid for persons 0 to 21 years of age. For Medicaid to cover ABA services through a licensed provider they must be ordered by a physician and be prior authorized by Medicaid.

ABA is accessed through your Managed Care Organization. All Medicaid eligible children are enrolled in the Medicaid Managed Care Program for their Specialized Behavioral Health Services even if they may have Legacy Medicaid for their Physical Health Services.

- **Aetna Better Health** 1-855-242-0802
- **Healthy Blue** 1-844-406-2389
- **AmeriHealth Caritas** 1-888-756-0004

Revised 4.25.19
If you are not sure who your Managed Care Organization is you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out which Managed Care Organization you are covered under.

**Mental Health and Substance Use Services**
Children and youth may receive mental health and substance use services if it is medically necessary. These services include necessary assessments and evaluation; individual and/or group therapy; medication management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; crisis services, behavior intervention plan development; multi-systemic therapy, functional family therapy, homebuilders, residential and intensive outpatient substance use disorder treatment; substance use detox; mental health residential treatment in a therapeutic group home; treatment in a psychiatric residential facility and inpatient psychiatric treatment.

**How to Access Mental Health and Substance Use Care**
How a person gets these services depends on the type of coverage they have.

If the member is **enrolled in a Medicaid Managed Care Program**, they can access services toll free by calling their plan using the numbers listed below. All Medicaid eligible children are enrolled in Medicaid Managed Care Program for their Specialized Behavioral Health Services even if they may have Legacy Medicaid for their Physical Health Services.

- Aetna Better Health 1-855-242-0802
- AmeriHealth Caritas Louisiana 1-888-756-0004
- Healthy Blue 1-844-521-6941
- Louisiana Healthcare Connections 1-866-595-8133
- United Healthcare Community Plan 1-866-658-5499

If you are not sure who your Managed Care Organization is you can contact the Medicaid Managed Care Program Line at 1-855-229-6848 to find out which Managed Care Organization you are covered under.

If a member is **part of the Coordinated System of Care (CSoC)** that helps at-risk children and youth who have serious behavioral health challenges, they can access services by contacting Magellan at 1-800-424-4489/TTY 1-800-424-4416. CSoC offers services and supports that help these children and youth return to or remain at home. Services include: youth support and training, parent support and training, independent living skill building services, and short-term respite. Parents and guardians will be assisted in selecting a provider in their area to best meet the needs of the child or youth and the family. Members can apply for CSoC by contacting their Managed Care Organization and requesting a Child and Adolescent Needs Assessment (CANS). If you screen positive on the CANS assessment the MCO will connect you to Magellan to complete the referral.
The rest of your medical services will either be accessed through Legacy Medicaid if you have Legacy Medicaid for your physical health services or through your Managed Care Organization if you chose to “opt in” to the Medicaid Managed Care Program for your physical health services.

Chisholm Class Members (Medicaid eligible children who are on the DD Request for Services Registry) are allowed to participate in the Medicaid Managed Care Program if they “opt in.” For more information about these options, contact the Medicaid Managed Care Program hotline toll free at 1-855-229-6848.

**EPSDT Exams and Checkups**
Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history; physical exam; immunizations; laboratory tests, including lead blood level assessment; vision and hearing checks; and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed.

EPSDT screens may help to find problems, which need other health treatment or additional services. **Children under 21 are entitled to receive all medically necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.**

**Personal Care Services**
Personal Care Services (PCS) are provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing, toileting and personal hygiene. PCS do not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid Home Health program or Extended Home Health program covers those medical services. PCS must be ordered by a physician. The PCS provider must request approval for the service from Medicaid or the Managed Care Organization.

**Extended Skilled Nursing Services**
Children and youth may be eligible to receive skilled nursing services in the home. These services are provided by a home health agency. A physician must order this service. Once ordered by a physician, the home health agency must request approval for the service from Medicaid or the Managed Care Organization.

**Physical Therapy, Occupational Therapy, Speech Therapy and Audiology Services**
If a child or youth wants rehabilitation services such as physical, occupational or speech therapy, or audiology services, these services can be provided at school, in an early intervention center, in an outpatient facility, in a rehabilitation center, at home, or in a combination of settings, depending on the child’s needs.

For Medicaid to cover these services at school (ages 3 to 21), or early intervention centers and EarlySteps (ages 0 to 3), the services must be part of the Individualized Education Plan (IEP) or

Revised 4.25.19
Individualized Family Service Plan (IFSP). For Medicaid to cover the services through an outpatient facility, rehabilitation center, or home health, they must be ordered by a physician and be prior-authorized by Medicaid or the Managed Care Organization.

For information on receiving these therapies contact your school or early intervention center or other providers. EarlySteps can be contacted toll-free at 1-866-327-5978. Call the Specialty Care Resource Line for referral assistance at 1-877-455-9955 for Legacy Medicaid or call your Managed Care Organization using the contacts listed above under Mental Health to locate other therapy providers.

**Medical Equipment and Supplies**

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, or improve physical or mental conditions. Medical equipment and supplies must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid or the Managed Care Organization.

If you need a service that is not listed above contact the Specialty Care Resource Line toll-free at 1-877-455-9955 or TTY 1-877-544-9544 or the participant’s Managed Care Organization Enrollee Services or Medicaid Managed Care Case Manager.

Revised 4.25.19
How to Locate Legacy Medicaid Services & Medical Equipment for the Home

CAN MEDICAID HELP YOU?

PERSONAL CARE SERVICES
Personal care services (PCS) are provided by a trained worker. They may be needed if your child has a disability, illness, or injury and needs help with things like eating, bathing, dressing or grooming. PCS does not include medical or nursing tasks, like giving medicine, tube feeding, or suctioning. PCS is not a substitute for child care. A physician must order this service. Personal Care Services must be prior authorized.

EXTENDED HOME HEALTH
Extended Home Health is home nursing care for people who need more skilled care than PCS. Home Health agencies can also provide physical, occupational and speech therapy in the home if this is medically necessary. There is no fixed limit on how many nurse visits or how long the nurse can be in the home for people under age 21. A physician must order this service. Extended Home Health Services must be prior authorized.

MEDICAL EQUIPMENT AND SUPPLIES
Children are entitled to medical supplies and equipment needed to help with physical or mental conditions. This includes lifts, wheelchairs, and other devices to help the family deal with a child’s medical condition. It also includes necessary dietary or nutritional assistance, and diapers or pull-ups if they are needed because of a medical problem. Medical Equipment and Supplies must be prescribed by a physician and prior authorized.

CUSTOMER SERVICE INFORMATION FOR MEDICAID INQUIRIES:

If you are unable to locate an Extended Home Health provider or a Personal Care Services (PCS) provider, or if you have an authorization for services but are not receiving them, please call toll-free 1-888-758-2220.

Specialty Care Help Desk • 1-877-455-9955
Medicaid Eligibility Hotline • 1-888-342-6207
Medicaid Services Chart • www.ldh.la.gov/medicaidservices
E-mail • medicaidweb@la.gov
Medicaid Website • www.medicaid.la.gov

What if a provider is not available, or if the provider can’t find staff?
If you cannot find a provider of any services you need in your area willing to submit a request, contact your support coordinator. If you do not have a support coordinator, contact Louisiana Department of Health (LDH) directly at 1-888-758-2220 and tell them you cannot find a provider. LDH will take all reasonable steps to find a willing and able provider within ten days.
NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan’s member services department with questions about how to access care.

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID SERVICES CHART

April 2019

* Exclusion from this list does not necessarily mean that a service is not covered. Please call one of the appropriate contacts for questions regarding coverage of services not listed on this chart.
NOTE: The points of contact listed in this document is applicable to Medicaid recipients in the fee-for-service Medicaid program. Healthy Louisiana Plan members should contact their Plan’s member services department with questions about how to access care.

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<tr>
<td>Adult Denture Services</td>
<td>Dentist</td>
<td>Medicaid recipients 21 years of age and older. (Adults, 21 and over, certified as Specified Low Income Medicare Beneficiary (SLMB) only, PACE, Take Charge Plus or other programs with limited benefits are not eligible for dental services.)</td>
<td>Examination, x-rays (are only covered if in conjunction with the construction of a Medicaid-authorized denture) dentures, denture relines, and denture repairs. Only one complete or partial denture per arch is allowed in an eight-year period. The partial denture must oppose a full denture. Two partials are not covered in the same oral cavity (mouth). Additional guidelines apply.</td>
<td>MCNA Dental administers the dental benefits for eligible Medicaid recipients. Contact MCNA Dental to locate a network provider and for questions about covered dental services. Recipients that reside in an Intermediate Care Facility for Developmental Disabilities (ICF/DD) will continue to receive adult denture services through the Fee-For-Service Dental Services Program.</td>
<td>MCNA Dental 1-855-702-6262 Visit online at <a href="http://www.MCNALA.net">www.MCNALA.net</a> Brandon Bueche 225/384-0460 Andrea Perry 225/342-7877</td>
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| Applied Behavior Analysis (ABA)             | Medicaid enrolled ABA provider | 1. be from birth up to 21 years of age; 2. exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, etc.); 4. be medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID); 5. be diagnosed by a qualified health care professional with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder; 6. have a comprehensive diagnostic evaluation by a qualified health care professional; and have a prescription for ABA-based therapy services ordered by a qualified health care professional. | ABA-based therapy services shall be rendered in accordance with the individual’s treatment plan.                                                                                                                                 | All medically necessary services must be prescribed by a physician and [Prior Authorization](#) is required. The provider of services will submit requests for Prior Authorization. | Aetna [www.aetnabetterhealth.com/louisiana](#)  
AmeriHealth Caritas [www.amerihealthcaritasla.com](#)  
Healthy Blue [www.myhealthyblue.la.com](#)  
Louisiana Healthcare Connections [www.louisianahealthconnect.com](#)  
United Healthcare Community Plan [www.uhccommunityplan.com](#) |

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<tr>
<td>Audiological Services –See EarlySteps; EPSDT Screening Services; Hospital-Outpatient services; Physician/Professional Services; Rehabilitation Clinic Services; Therapy Services</td>
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<td>SERVICE</td>
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<td>Behavioral Health Services – Adults</td>
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<td>Chemotherapy Services-See Hospital-Outpatient Services; Physician/Professional Services</td>
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<tr>
<td>Chiropractic Services</td>
<td>EPSDT Medical Screening Provider/PCP</td>
<td>Medicaid recipients 0 through 20 years of age.</td>
<td>Spinal manipulations.</td>
<td>Medically necessary manual manipulations of the spine when the service is provided as a result of a referral from an EPSDT medical screening provider or Primary Care Provider (PCP).</td>
<td>Helen Prett 225/342-8932</td>
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| Coordinated System of Care (CSoC) Program | To make a referral, contact the child/youth’s Healthy Louisiana Plan. Note that the parent/caregiver must participate in the referral. The Healthy Louisiana Plan information is as follows: | CSoC services are administered by Magellan Health Services of Louisiana. |  |
|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|  |
|                                         | Aetna Better Health: 1-855-242-0802 | Magellan Health Services of Louisiana 1-800-424-4489 |  |
|                                         | AmeriHealth Caritas: 1-888-756-0004 |                                           |  |
|                                         | Healthy Blue: 1-844-521-6941 |                                           |  |
|                                         | Louisiana Healthcare Connections: 1-866-595-8133 |                                           |  |
|                                         | United Health Care: 1-866-675-1607 |                                           |  |
| **The Healthy Louisiana Plan will connect you with Magellan to complete the referral** | Any child/youth experiencing a serious emotional disturbance who is at risk of out-of-home placement. A recipient must be 5 to 20 years old and meet the level of care or level of need through a Child and Adolescent Needs and Strengths (CANS) comprehensive assessment | 1. Wraparound Facilitation  
2. Parent Support & Training  
3. Youth Support & Training  
4. Independent Living/Skills Building  
5. Short Term Respite Care  
6. Case Conference |  |

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<td>Dental Care Services - See Adult Denture Services; and EPSDT Dental Services</td>
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<td>Durable Medical Equipment (DME)</td>
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<tr>
<td><strong>EarlySteps</strong> (Infant &amp; Toddler Early Intervention Services)</td>
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<td>Children ages birth to three who have a developmental delay of at least 1.5 SD (standard deviations) below the mean in two areas of development listed below:</td>
<td>Covered Services (Medicaid Covered)</td>
<td>All services are provided through a plan of care called the Individualized Family Service Plan. Early Intervention is provided through EarlySteps in conformance with Part C of the Individuals with Disabilities Education Act. (IDEA).</td>
<td>Office for Citizens with Developmental Disabilities</td>
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<td>a. cognitive development</td>
<td>-Family Support Coordination (Service Coordination)</td>
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<td>1-866-783-5553 or 1-866-earlystep</td>
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<td>b. physical development (vision &amp; hearing)</td>
<td>-Occupational Therapy</td>
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<td>For families</td>
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<td>c. -- communication development</td>
<td>-Physical Therapy</td>
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<td>Brenda Sharp</td>
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<td>social or emotional development</td>
<td>-Speech/Language Therapy</td>
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<td>225/342-8853</td>
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<td>d. adaptive skills development (also known as self-help or daily living skills)</td>
<td>-Psychology</td>
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<td>1. Children with a diagnosed medical condition with a high probability of resulting in developmental delay.</td>
<td>-Audiology</td>
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<td>EarlySteps also provides the following services, not covered by Medicaid:</td>
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<td>-Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services).</td>
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<td>-Medical Services for diagnostic and evaluation purposes only.</td>
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<td>-Special Instruction</td>
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<td>-Vision Services</td>
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<td>-Assistive Technology devices and services</td>
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<td>-Social Work</td>
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<td>-Counseling Services/Family Training</td>
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<td>-Nutrition</td>
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<td>-Sign language and cued language services.</td>
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<tbody>
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<tr>
<td>EPSDT Dental Services</td>
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<tr>
<td>EPSDT Personal Care Services</td>
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<tr>
<td>EPSDT Screening Services</td>
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<tr>
<td>Eyewear – See Vision Services</td>
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<tr>
<td>Family Planning Services – Take Charge Plus</td>
<td>Any Medicaid provider who offers family planning services.</td>
<td>All Louisiana residents of child bearing age regardless of gender with an income at or below 138% of the Federal Poverty level. Pregnant women are excluded from this program.</td>
<td>Family planning related services and care related to: • Birth control (pills, implants, injections, condoms, and IUDs) • Cervical cancer screening and treatment for most abnormal results • Contraceptive counseling and education • Prescriptions, and follow-up visits to treat STIs • Treatment of major complications from certain family planning procedures • Voluntary sterilization for males and females (over age 21) • Vaccines for both males and females for the prevention of HPV • Transportation to family planning appointments</td>
<td>Take Charge Plus is limited to family planning services and family planning related services. There are no enrollment fees, no premiums, co-payments or deductibles. All Medicaid providers including American Indian “638” Clinics, RHCs and FQHCs are reimbursed at established fee-for-service rates published in the Take Charge Plus fee schedule.</td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td>Family Planning Services in Physician’s Office – See Physician/Professional Services</td>
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<tr>
<td>Federally Qualified Health Centers (FQHC)</td>
<td>Nearest FQHC The American Indian Clinic</td>
<td>All Medicaid recipients.</td>
<td>Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists</td>
<td>There are 3 components that may be provided: 1) Encounter visits; 2) EPSDT Screening Services; and 3) EPDST Dental, and Adult Denture Services.</td>
<td>Irma Gauthier 225/342-5691</td>
</tr>
<tr>
<td>Free Standing Birthing Centers</td>
<td>Certified Nurse Midwife or Licensed Midwife</td>
<td>All Medicaid eligible pregnant women</td>
<td>Vaginal delivery services for females who have had a low risk, normal pregnancy, prenatal care and that are expected to have an uncomplicated labor and normal vaginal delivery.</td>
<td>A Free Standing Birthing Center is a free standing facility, separate from a hospital. Stays for delivery are usually less than 24 hours. Epidural anesthesia is not provided for deliveries at Free Standing Birthing Centers.</td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td>Hearing Aids - See Durable Medical Equipment</td>
<td>Durable Medical Equipment Provider</td>
<td>Medicaid recipients 0 through 20 years of age.</td>
<td>Hearing Aids and any related ancillary equipment such as earpieces, batteries, etc. Repairs are covered if the Hearing Aid was paid for by Medicaid.</td>
<td>All services must be Prior Authorized and the DME provider will arrange for the request of Prior Authorization.</td>
<td>Irma Gauthier 225/342-5691</td>
</tr>
<tr>
<td>Hemodialysis Services - See Hospital-Outpatient Services</td>
<td>Dialysis Centers Hospitals</td>
<td>All Medicaid recipients.</td>
<td>Dialysis treatment (including routine laboratory services); medically necessary non-routine lab services; and medically necessary injections.</td>
<td></td>
<td>Helen Prett 225/342-8932</td>
</tr>
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<tr>
<td><strong>Home Health</strong></td>
<td>Physician</td>
<td>All Medicaid recipients. Medically Needy (Type Case 20 &amp; 21) recipients are not eligible for Aide Visits, Physical Therapy, Occupational Therapy, Speech/Language Therapy. EPSDT Home Health is provided to the medically needy if the recipient is under the age of 21.</td>
<td>• Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits • Physical Therapy • Occupational Therapy • Speech/Language Therapy</td>
<td>Recipients receiving Home Health must have physician’s prescription and signed plan of care. PT, OT, and Speech/Language Therapy require <a href="#">Prior Authorization</a>.</td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td><strong>Home Health - Extended</strong></td>
<td>Physician</td>
<td>Medicaid recipients 0 through 20 years of age.</td>
<td>Multiple hours of skilled nurse services. All medically necessary medical tasks that are part of the plan of care can be administered in the home.</td>
<td>Recipients receiving extended nursing services must have a letter of medical necessity and physician’s prescription. Extended Skilled nursing services require <a href="#">Prior Authorization</a>.</td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
<td>Hospice Provider/Physician</td>
<td>All Medicaid recipients. Hospice eligibility information: 1-800-877-0666 Option 2</td>
<td>Medicare allowable services.</td>
<td></td>
<td>Helen Prett 225/342-8932</td>
</tr>
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<tr>
<td>Hospital Claim Questions - Inpatient and Outpatient Services, including Emergency Room Services</td>
<td>Physician/Hospital</td>
<td>All Medicaid recipients. Medically Needy (Type Case 20 &amp; 21) under age 22 are not eligible for Inpatient Psychiatric Services.</td>
<td>Inpatient and Outpatient Hospital Services, including Emergency Room Services</td>
<td>All Questions Regarding Denied Claims and/or Bills for Inpatient and Outpatient Hospital Services, including Emergency Room Services</td>
<td>Recipients should first contact the provider, then may contact an MMIS Staff Member at 225/342-3855 if the issue cannot be resolved. Providers should contact Provider Relations at 1-800-473-2783</td>
</tr>
<tr>
<td>Hospital - Inpatient Services</td>
<td>Physician/Hospital</td>
<td>All Medicaid recipients. Medically Needy (Type Case 20 &amp; 21) under age 22 are not eligible for Inpatient Psychiatric Services.</td>
<td>Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely &amp; adequately in a hospital setting. Includes those basic services that a hospital is expected to provide.</td>
<td></td>
<td>Providers: <a href="mailto:ProviderRelations@la.gov">ProviderRelations@la.gov</a>. Members: <a href="mailto:Healthy@la.gov">Healthy@la.gov</a></td>
</tr>
<tr>
<td>Hospital - Outpatient Services</td>
<td>Physician/Hospital</td>
<td>All Medicaid recipients.</td>
<td>Diagnostic &amp; therapeutic outpatient services, including outpatient surgery and rehabilitation services. Therapeutic and diagnostic radiology services. Chemotherapy Hemodialysis</td>
<td>Outpatient rehabilitation (physical therapy, occupational therapy, and speech therapy) require Prior Authorization. Provider will submit request for Prior Authorization.</td>
<td>Providers: <a href="mailto:ProviderRelations@la.gov">ProviderRelations@la.gov</a>. Members: <a href="mailto:Healthy@la.gov">Healthy@la.gov</a></td>
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<tr>
<td>Hospital - Emergency Room Services</td>
<td>Physician/Hospital</td>
<td>All Medicaid recipients.</td>
<td>Emergency Room services.</td>
<td>No service limits.</td>
<td>Providers: <a href="mailto:ProviderRelations@la.gov">ProviderRelations@la.gov</a>  Members: <a href="mailto:Healthy@la.gov">Healthy@la.gov</a></td>
</tr>
</tbody>
</table>
| Immunizations  
*See FQHC; EPSDT Screening Services; Physician/Professional Services; Rural Health Clinics* | Physician | All Medicaid recipients. | Most diagnostic testing and radiological services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays. | All requests for any radiology services requiring prior approval are initiated by the ordering physician. Recipients may follow up with the ordering physician for the status of any ordered radiology service. | Helen Prett 225/342-8932 |
| Laboratory Tests and Radiology Services | Physician | All Medicaid recipients. | | | |

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</table>
| **Long Term - Personal Care Services** (LT-PCS) | Contact: Louisiana Options in Long Term Care (Conduent) 1-877-456-1146 | All Medicaid recipients age 65 or older, or age 21 or older with disabilities (meets Social Security Administration disability criteria), meet the medical standards for admission to a nursing facility and additional targeting criteria, and be able to participate in his/her care and direct the services provided by the worker independently or through a responsible representative. Applicant must require at least limited assistance with at least one Activity of Daily Living. | -Basic personal care-toileting & grooming activities.  
- Assistance with bladder and/or bowel requirements or problems.  
- Assistance with eating and food preparation.  
- Performance of incidental household chores, only for the recipient.  
- Accompanying, not transporting, recipient to medical appointments.  
- Grocery shopping, including personal hygiene items. | Recipients or the responsible representative must request the service.  
This program is NOT a substitute for existing family and/or community supports, but is designed to supplement available supports to maintain the recipient in the community.  
Once approved for services, the selected PCS Agency must obtain Prior Authorization.  
Amount of services approved will be based on assessment of assistance needed to perform daily living.  
Provided by PCS agencies enrolled in Medicaid. | Office of Aging and Adult Services (OAAS)  
Contact: Louisiana Options in Long Term Care (Conduent) 1-877-456-1146  
OAAS Helpline 1-866-758-5035 Anne Deitch 225/342-0222 |
| **Medical Transportation** (Emergency) | Emergency ambulance providers | All Medicaid recipients. | Emergency ambulance service may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the patient. | | Melanie Doucet (225-614-3222) |

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<th>Medical Transportation (Non-Emergency)</th>
<th>Medicaid recipients who ARE covered under a Healthy Louisiana managed care plan should contact the call centers as follows:</th>
<th>All Medicaid recipients with full benefits, except some who have Medicaid and Medicare.</th>
<th>Transportation to and from medical appointments.</th>
<th>Recipients should call dispatch offices 48 hours before the appointment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health</td>
<td>1-877-917-4150</td>
<td>The medical provider the recipient is being transported to, does not have to be a Medicaid enrolled provider but the services must be Medicaid covered services. The dispatch office will make this determination.</td>
<td>Transportation to out-of-state appointments can be arranged but requires Prior Authorization.</td>
<td>Same day transportation can be scheduled when absolutely necessary.</td>
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<tr>
<td>Healthy Blue</td>
<td>1-866-430-1101</td>
<td>Recipients under 17 years old must be accompanied by an attendant.</td>
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<td>AmeriHealth Caritas</td>
<td>1-888-913-0364</td>
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<tr>
<td>Louisiana Healthcare Connections</td>
<td>1-855-369-3723</td>
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<td>United Healthcare Community Plan</td>
<td>1-866-726-1472</td>
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| SERVICE | HOW TO ACCESS SERVICES | ELIGIBILITY | COVERED SERVICES | COMMENTS |
| Midwife Services (Certified Nurse Midwife) - See FQHC; Physician/Professional Services; Rural Health Clinics (Licensed Midwife) – See Freestanding Birthing Center |  |  |  |  |
| Nurse Practitioners/ Clinical Nurse Specialists - See FQHC; Physician/Professional Services; Rural Health Clinics |  |  |  |  |
| Nursing Facility | Medicaid recipients and persons who would meet Medicaid Long Term Care financial eligibility requirements and who meet nursing facility level of care as determined by OAAS. | Skilled Nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition. |  | Office of Aging and Adult Services (OAAS) |
|  |  |  |  | Contact: Louisiana Options in Long Term Care (Conduent) 1-877-456-1146 |

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<td>Occupational Therapy Services See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services</td>
</tr>
<tr>
<td>Optical Services – (See Vision Services for Eyewear)</td>
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<td>Orthodontic Services - See Dental Care Services</td>
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| Program of All-Inclusive Care for the Elderly (PACE)* |  | Participants are persons age 55 years or older, live in the PACE provider service area, are certified to meet nursing facility level of care and financially eligible for Medicaid long term care. Participation is voluntary and enrollees may disenroll at any time. | ALL Medicaid and Medicare services, both acute and long-term care | - Emphasis is on enabling participants to remain in community and enhance quality of life.  
- Interdisciplinary team performs assessment and develops individualized plan of care.  
- Each PACE program serves a specific geographic region.  
- PACE programs bear financial risk for all medical support services required for enrollees.  
- PACE programs receive a monthly capitated payment for Medicaid and Medicare eligible enrollees. | Office of Aging and Adult Services (OAAS)  
Contact: PACE GNO at (504) 945-1531  
Franciscan PACE Baton Rouge: (225)490-0640  
Franciscan PACE Lafayette (337) 470-4500 |

*Program available in New Orleans, Baton Rouge, and Lafayette area.

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| Pharmacy Services | Pharmacies | All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) receive their pharmacy benefits through Medicare Part D. Recipients enrolled in an MCO with only behavioral health services receive prescription benefits through the fee-for-service Medicaid program. | Covers prescription drugs EXCEPTIONS:  
  - Cosmetic drugs (Except Accutane);  
  - Cough & cold preparations;  
  - Anorexics (Except for Xenical);  
  - Fertility drugs when used for fertility treatment;  
  - Experimental drugs;  
  - Compounded prescriptions;  
  - Vaccines covered in other programs;  
  - Drug Efficacy Study Implementation (DESI) drugs;  
  - Erectile Dysfunction (ED) Medications  
  - Over the counter (OTC) drugs with some exceptions;  
  - Narcotics prescribed only for narcotic addiction | Co-payments ($0.50-$3.00) are required except for some recipient categories. NO co-payments for the following:  
  - Under age 21  
  - Pregnant women  
  - Long Term Care recipients  
  - American Indians/Alaska Natives  
  - Home and Community Based Waiver  
  - Influenza immunizations  
  - Emergency Services  
  - Family planning services  
  - Preventive medications as designated by the US Preventive Services Task Force A and B Recommendations  
  - Individuals receiving hospice care  
  - Women whose basis of Medicaid eligibility is breast or cervical cancer

Prescription limits: 4 per calendar month (The physician can override this limit when medically necessary.) *Limits do not apply to recipients under age 21, pregnant women, or those in Long Term Care.*

**Prior Authorization** is required for some drug categories if the medication is not on the Preferred Drug List (PDL). **Children are not exempt from this process.** The PDL can be accessed at www.lamedicaid.com.

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<tr>
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<th>Sharon Beckwith</th>
<th>225/342-9859</th>
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<tbody>
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<td></td>
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<td>Paul Knecht</td>
<td>225/342-2768</td>
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<td>For general</td>
<td>1-800-437-9101</td>
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<td>pharmacy questions:</td>
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<td>Physical Therapy - See EarlySteps; Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services; Therapy Services</td>
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<td>Physician Assistants - See FQHC; Physician/Professional Services; Rural Health Clinics</td>
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<td></td>
</tr>
<tr>
<td>Physician/Professional Services</td>
<td>Physician or Healthcare Professional</td>
<td>All Medicaid recipients.</td>
<td>Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists, physician assistant. Certain family planning services when provided in a physician’s office.</td>
<td>Some services require Prior Authorization. Providers will submit requests for Prior Authorization to DXC Technology. Services are subject to limitations and exclusions. Your physician or healthcare professional can help with this.</td>
<td>Immunizations: Norma Seguin 225/342-7513 Family Planning/Professional Services: Helen Prett 225/342-8932</td>
</tr>
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<tbody>
<tr>
<td>Pre-Natal Care Services</td>
<td>Physicians or Healthcare Professional</td>
<td>Female Medicaid recipients of child bearing age.</td>
<td>Office visits. Lab and radiology services.</td>
<td></td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td>Psychiatric Hospital Care Services - See Hospital-Inpatient Services</td>
<td>Physician</td>
<td>Medicaid recipients 0 through 20 years of age.</td>
<td>Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy</td>
<td>All services must be Prior Authorized. The provider of services will submit the request for Prior Authorization.</td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td>Rehabilitation Clinic Services</td>
<td>Physician</td>
<td>Medicaid recipients 0 through 20 years of age.</td>
<td>Occupational Therapy Physical Therapy Speech, Language and Hearing Therapy</td>
<td>All services must be Prior Authorized. The provider of services will submit the request for Prior Authorization.</td>
<td>Helen Prett 225/342-8932</td>
</tr>
<tr>
<td>Rural Health Clinics</td>
<td>Rural Health Clinic The American Indian Clinic</td>
<td>All Medicaid recipients</td>
<td>Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Covered benefits include medical, behavioral health, and dental.</td>
<td>There are 3 components that may be provided: 1) Encounter visits; 2) EPSDT Screening Services; and 3) EPDST Dental, and Adult Denture Services.</td>
<td>Irma Gauthier 225/342-5691</td>
</tr>
<tr>
<td>Sexually Transmitted Disease Clinics (STD)</td>
<td>OPH Public Health Units</td>
<td>All Medicaid recipients.</td>
<td>Testing, counseling, and treatment of all sexually transmitted diseases (STD). Confidential HIV testing.</td>
<td></td>
<td>Public Health Unit directory located at: <a href="http://ldh.la.gov/index.cfm/directory/category/192">http://ldh.la.gov/index.cfm/directory/category/192</a></td>
</tr>
</tbody>
</table>
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<tr>
<td>Speech and Language Evaluation and Therapy – See EarlySteps; Home Health; Hospital Outpatient Services; Rehabilitation Clinic Services; Therapy Services</td>
<td></td>
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</tr>
<tr>
<td>Support Coordination Services (Case Management) - Children’s Choice Waiver</td>
<td>Medicaid recipients must be in the Children’s Choice Waiver. There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: <a href="http://ldh.la.gov/index.cfm/page/134/n/137">http://ldh.la.gov/index.cfm/page/134/n/137</a></td>
<td>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.</td>
<td>Services must be prior authorized by LDH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the Prior Authorization.</td>
<td>Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553</td>
<td></td>
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<tr>
<td>Support Coordination Services (Case Management) - Community Choices Waiver</td>
<td></td>
<td>Medicaid recipients must be in the Community Choices Waiver (CCW). There is a Request for Services Registry (RFSR) for those requesting CCW Waiver services. Contact Louisiana Options in Long Term Care at 1-877-456-1146.</td>
<td>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.</td>
<td>Services must be prior authorized by LDH, Office of Aging and Adult Services (OAAS). The provider will submit requests for the Prior Authorization.</td>
<td>Office of Aging and Adult Services (OAAS) 1-866-758-5035 Participants call 1-866-758-5035 or 225-219-0643</td>
</tr>
<tr>
<td>Support Coordination Services (Case Management) - EPSDT Targeted Populations</td>
<td></td>
<td>Must be Medicaid eligible and on the DD Request for Services Registry prior to receipt of case management services; or any Medicaid recipient 3 through 20 years of age for whom support coordination is medically necessary (Call SRI at 1-800-364-7828). To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office</td>
<td>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.</td>
<td>Support Coordination Services must be prior authorized by LDH, BHSF, and Waiver Compliance Section. The Support Coordination Agency will submit requests for the Prior Authorization to SRI. For other EPSDT services, see that portion of the chart.</td>
<td>SRI 1-800-364-7828 Must be on the DD Request for Services Registry. However, if the child is no longer eligible to remain on the registry, the family can appeal the notice that is sent out. The LDH will evaluate the recipients eligibility to receive “special needs” case management.</td>
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<tr>
<td>Support Coordination Services (Case Management) - Infants and Toddlers</td>
<td>Medicaid recipients must be 0 to 3 years of age and have a developmental delay or an established medical condition and eligible for the EarlySteps system. Contact information is located at: <a href="http://ldh.la.gov/index.cfm/page/139/n/139">http://ldh.la.gov/index.cfm/page/139/n/139</a></td>
<td>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care in EarlySteps.</td>
<td>Services must be authorized by EarlySteps. Authorizations are approved through the Individualized Family Service Plan (IFSP) process.</td>
<td>Office for Citizens with Developmental Disabilities (OCDD)</td>
</tr>
<tr>
<td>Support Coordination Services (Case Management) - New Opportunities Waiver (NOW)</td>
<td>Medicaid recipients must be receiving the NOW. There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office contact information is located at: <a href="http://ldh.la.gov/index.cfm/page/134/n/137">http://ldh.la.gov/index.cfm/page/134/n/137</a></td>
<td>Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section of this document.</td>
<td>Services must be prior authorized by LDH, Office for Citizens with Developmental Disabilities, Waiver Supports and Services. The support coordinator will submit requests for the Prior Authorization.</td>
<td>Office for Citizens with Developmental Disabilities, Waiver Supports and Services 1-866-783-5553 Complaints Line: 1-800-660-0488</td>
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<td>Support Coordination Services (Case Management) – Residential Options Waiver</td>
</tr>
<tr>
<td>Support Coordination Services (Case Management) – Supports Waiver</td>
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| Therapy Services | Recipients have the choice of services from the following provider types: Home Health; Hospital-Outpatient Services; Rehabilitation Clinic Services | Medicaid recipients **0 through 20 years of age.** | • Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only.)<br>• Occupational Therapy<br>• Physical Therapy<br>• Speech & Language Therapy | Covered services can be provided in the home through Home Health and Rehabilitation Clinics. Services provided by Rehabilitation Clinics can also be provided at the clinic. Services provided through Hospital-Outpatient Services must be provided at the facility/clinic. Covered services may be provided in addition to services provided by EarlySteps/EICs or School Boards if prescribed by a physician and Prior Authorized.<br>All medically necessary services must be prescribed by a physician and **Prior Authorization** is required. The provider of services will submit requests for Prior Authorization. | Helen Prett 225/342-8932

NOTE: For details on services provided in Home Health, Rehabilitation Clinic, or Hospital-Outpatient settings, please refer to those sections of this Medicaid Services Chart. |

| Therapy Services continued | EPSDT Health Services-Early Intervention Centers (EIC) or EarlySteps Program | Medicaid recipients **under 3 years of age.** | • Audiological Services<br>• Occupational Therapy<br>• Physical Therapy<br>• Speech & Language Therapy<br>• Psychological Therapy | All EPSDT Health Services through EICs and EarlySteps must be included in the infant/toddler’s Individualized Family Services Plan (IFSP). If services are provided by an EIC or EarlySteps, Prior Authorization requirements are met through inclusion of services on the IFSP. | Helen Prett 225/342-8932 |

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</table>
| Therapy Services  | Therapy Services continued | EPSDT Health Services - Local Education Agencies (LEA) e.g. School Boards | Medicaid recipients 3 through 20 years of age. | • Audiological Evaluation and Therapy  
• Occupational Therapy Evaluation and Treatment services  
• Physical Therapy Evaluation and Treatment services  
• Speech & Language Evaluation and Therapy  
• Behavioral Health, Evaluation and Therapy Services  
• Nursing Services | Services are performed by the Local Education Agencies (LEA)  
All EPSDT Health Services must be included in the child’s Individualized Education Program (IEP).  
If services are provided by a, LEA Prior Authorization requirements are met through inclusion of services on the IEP. | Anissa Young-Ned 225/342-6885 |
| Therapy Services  | Therapy Services continued | Physician Recipients 21 years of age and older.  
Medically Needy (Type Case 20 & 21) recipients are not eligible  
Physical Therapy, Occupational Therapy, Speech/Language Therapy in a Home Health setting. | Medicaid recipients 21 years of age and older. | • Physical Therapy  
• Occupational Therapy  
• Speech/Language Therapy | PT, OT, and Speech/Language Therapy require a physician’s prescription.  
PT, OT, and Speech/Language Therapy require Prior Authorization. | Helen Prett 225/342-8932 |
| Transportation    | Transportation | See Medical Transportation | | | For details on services provided in Home Health or Hospital-Outpatient settings, please refer to those sections of this Medicaid Services Chart. | |

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</thead>
<tbody>
<tr>
<td>Tuberculosis Clinics</td>
<td>Office of Public Health Local Health Unit</td>
<td>All Medicaid recipients</td>
<td>Treatment and disease management services including physician visits, medications and x-rays.</td>
<td></td>
<td>TB Control Directory found at: <a href="http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/TBDirectory2018.pdf">http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/TBDirectory2018.pdf</a></td>
</tr>
<tr>
<td>Vision Services (Eyewear)</td>
<td>Optometrist, Ophthalmologist or Optical Supplier</td>
<td>Recipients 0 through 20</td>
<td>Regular eyeglasses when they meet a certain minimum strength requirement. <strong>Medically necessary</strong> specialty eyewear and contact lenses with <strong>prior authorization</strong>. Contact lenses are covered if they are the <strong>only</strong> means for restoring vision. <strong>Recipients 21 and over</strong></td>
<td></td>
<td>Irma Gauthier 225/342-5691</td>
</tr>
<tr>
<td>X-Ray Services - See Laboratory Tests and X-Ray Services</td>
<td></td>
<td></td>
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<td>WAIVER SERVICES:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>See Specific Waiver</td>
</tr>
</tbody>
</table>
| Adult Day Health Care (ADHC) |     | There is a Request for Services Registry (RFSR) for those requesting any of the waiver services below. | Individuals 65 years of age or older, who meet Medicaid financial eligibility, imminent risk criteria and meet the criteria for admission to a nursing facility; or age 22-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility | - Adult Day Health Care services  
- Transition Services  
- Support Coordination  
- Transition Intensive Support Coordination | This is a home and community - based alternative to nursing facility placement. | Office of Aging and Adult Services (OAAS)  
To Apply Contact: Louisiana Options in Long Term Care  
1-877-456-1146  
Participants call  
1-866-758-5035 or 225/219-0643 |

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</table>
| Children’s Choice |                        | Child must be on the DD Request for Services Registry, less than 21 years old, disabled according to SSI criteria, require ICF/DD level of care, have income less than 3 times SSI amount, resources less than $2,000 and meet all Medicaid non-financial requirements. | - Center Based Respite  
- Environmental Accessibility Adaptation  
- Specialized Medical Equipment and Supplies  
- Family Training  
- Professional Services: Aquatic Therapy, Art Therapy, Music Therapy, Sensory Integration, Hippotherapy/Therapeutic Horseback Riding  
- Housing Stabilization/ Housing Stabilization Transition -Crisis and Non-Crisis Provisions | There is a $16,410 limit per individual plan year. ($1500 for Case Management balance for other services).  
* Call the Office for Citizens with Developmental Disabilities or local Districts/Authorities for status on the Request for Services Registry. (See Appendix for telephone numbers)  
Complaints Line: 1-800-660-0488 | Office for Citizens with Developmental Disabilities Districts/ Authorities (SYSTEM ENTRY) contact information is located at: http://ldh.la.gov/index.cfm/page/134/n/137  
Anita Lewis 225/342-0095 |
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</thead>
</table>
|                   | Community Choices Waiver (CCW) |                        | Individuals 65 years of age or older, who meet Medicaid financial eligibility and meet the criteria for admission to a nursing facility; or age 21-64 who are disabled according to Medicaid standards or SSI disability criteria, meet Medicaid financial eligibility, and meet the criteria for admission to a nursing facility | - Support Coordination  
- Environmental Accessibility Adaptation  
- Transition Intensive Support Coordination  
- Transition Service  
- Personal Assistance Services  
- Adult Day health Care Services  
- Assistive Devices and Medical - Supplies  
- Skilled Maintenance Therapy Services  
- Nursing Services  
- Home Delivered Meal Services  
- Caregiver Temporary Support Services | This is a home and community-based alternative to nursing facility placement. | Office of Aging and Adult Services (OAAS)  
To Apply Contact: Louisiana Options in Long Term Care  
1-877-456-1146  
Participants call 1-866-758-5035 or 225/219-0643 |

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<tr>
<td>New Opportunities Waiver (NOW)</td>
<td></td>
<td>Individuals three(3) years of age or older, who have a developmental disability which manifested prior to the age of 22, and who meet both SSI Disability criteria and the level of care determination for an ICF/DD.</td>
<td>An array of services to provide support to maintain persons in the community: Individual Family Support, Day and Night; Shared Supports; Center Based Respite Care; Community Integration Development; Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies; Substitute Family Care Services; Supported Living; Day Habilitation; Supported Employment; Prevocational Services; Professional Services; One Time Transitional Expense; Skilled Nursing; Housing Stabilization/ Housing Stabilization Transition and Personal Emergency Response System, Adult Companion Care.</td>
<td>*Call the Office for Citizens with Developmental Disabilities Districts/Authorities/Local Regional Offices for status on the Request for Services Registry. (See Appendix for telephone numbers)</td>
<td>Office for Citizens with Developmental Disabilities Districts/Authorities SYSTEM ENTRY contact information is located at: <a href="http://ldh.la.gov/index.cfm/page/134/n/137">http://ldh.la.gov/index.cfm/page/134/n/137</a> Kim Kennedy 225/342-4464</td>
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<tr>
<td><strong>Residential Options Waiver (ROW)</strong></td>
<td></td>
<td>Individuals, birth to end of life, who have a developmental disability which manifested prior to the age of 22. (Must meet the Louisiana definition of DD).</td>
<td>Covered services include: Support Coordination, Community Living Supports, Host Home Services, Companion Care Services, Shared Living, Respite Care-Out of Home, Personal Emergency Response System, One Time Transition Services, Environmental Accessibility Adaptations, Assistive Technology/Specialized Medical Equipment and Supplies, Transportation-Community Access, Professional Services, Nursing Services, Dental Services, Supported Employment, Prevocational Services, Day Habilitation and Housing Stabilization/Housing Stabilization Transition</td>
<td>Complaints Line: 1-800-660-0488</td>
<td>Office for Citizens with Developmental Disabilities Districts/Authorities /Local Regional offices. System Entry contact information is located at: <a href="http://ldh.la.gov/index.cfm/page/134/n/137">http://ldh.la.gov/index.cfm/page/134/n/137</a> Jeannathan H. Anderson 225/342-5647</td>
</tr>
<tr>
<td><strong>Supports Waiver</strong></td>
<td></td>
<td>Individuals age 18 and older who have been diagnosed with a Developmental Disability which manifested prior to age 22. (Must meet the Louisiana definition of DD).</td>
<td>Covered services include: Support Coordination, Supported Employment, Day Habilitation, Prevocational Habilitation, Respite, Personal Emergency Response System, Housing Stabilization Transition, Housing Transition, and Habilitation</td>
<td>Complaints Line: 1-800-660-0488</td>
<td>Office for Citizens with Developmental Disabilities Human Services District or Authority Offices System Entry contact information is located at: <a href="http://ldh.la.gov/index.cfm/page/134/n/137">http://ldh.la.gov/index.cfm/page/134/n/137</a> Rosemary Morales 225/342-0095</td>
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Frequently Asked Children’s Choice Questions

1. What is Children’s Choice?
Children’s Choice is a program designed to help families who provide in-home care and support for their children with developmental disabilities. Children’s Choice assists by providing funding for medical care, home modifications, care-giving assistance and support, and other specialty services. Children’s Choice is a support program designed to be flexible enough to let families choose when they need the covered services.

Children’s Choice is intended to supplement the care and support that eligible children already receive at home, through their extended families or that is already available within local communities. Funds available through Children’s Choice are capped at $16,410 per care plan year. Recipients are also eligible for services through the Medicaid State Plan which includes all medically necessary services.

2. What are the eligibility requirements for Children's Choice?
• Child is on the Request for Services Registry.
• Child is under twenty-one (21) years of age.
• Child is disabled according to SSI criteria.
• Child requires the level of care provided in an ICF/DD facility (institution).
• Child has income less than three (3) times the SSI amount.
• Child has resources less than $2,000.
• Child meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.).
• Child’s plan of care meets the health and welfare needs of the child.
• Appropriate level of care can be provided outside an institution.

3. What services are available through Children’s Choice?
- Support Coordination
- Family Support
- Center-based Respite
- Environmental Accessibility Adaptations
- Family Training
- Specialized Medical Equipment and Supplies
- Therapy Services
- Aquatic Therapy
- Art Therapy
- Music Therapy
- Hippotherapy
- Therapeutic Horseback Riding
- Sensory Integration Therapy
- Housing Stabilization Transition Services
- Housing Stabilization
- Medical coverage via the Medicaid program

4. What are some of the things that would be covered by the Medicaid card?
When a child is certified for Children’s Choice, they will be entitled to receive medical services and get a Medicaid card.

Some services include physician services, hospital services, Applied Behavioral Analysis-Based Therapy, home health, additional personal care services, durable medical equipment, pharmacy services and many others.

5. What is the New Opportunities Waiver (NOW)?
The NOW is a comprehensive community-based waiver program that serves both children and adults with developmental disabilities. Traditionally, Medicaid pays for and provides services for these individuals in
institutional settings. Through the waiver program, citizens with developmental disabilities have greater flexibility to choose where they want to live, and the services and supports that best suit their needs, while still receiving Medicaid benefits.

The NOW pays for services such as personal care attendants, environmental modifications, assistive devices, respite care and many other services. In addition, day/vocational services and residential alternatives (such as supervised independent living and extended family living) are provided.

6. How can a parent find out what their child’s request date is on the Request for Services Registry?
A parent can call Toll Free 1-866-783-5553 or contact their Human Services Authorities or Districts to obtain their child’s request date and Screening for Urgency of Need (SUN) score.

7. How often are the opportunity letters offering Children’s Choice to families sent out and will families who initially declined Children’s Choice be contacted again in the future to see if they have changed their mind, especially if there are changes in the program?
When Children’s Choice opportunities are available, letters go out to families. Families who have initially said “no” will not be offered a Children’s Choice Waiver opportunity again. Their names will be removed from the Developmental Disabilities Request for Services Registry (DD RFSR). Once a recipient’s name has been removed from DD Request for Service Registry the individual/family will have to start over again by contacting their Human Services Authorities or Districts to complete the screening process.

8. What if I think my child needs more services in excess of the yearly limit?
Children’s Choice is designed for children under age twenty-one (21) with low to moderate needs and whose families provide most of the care and support. But if a crisis situation develops and additional supports are warranted, there are crisis provisions designed to meet the needs of families on a case-by-case basis.

9. I’ve waited several years for community services. If I accept Children’s Choice instead of the NOW, do I lose the opportunity to get the NOW if my child’s needs change?
If a child’s needs significantly change and a crisis designation is met, the child’s name would be returned to the Request for Services Registry with the child’s original request date. Additionally, once your child turns age twenty-one (21), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult Waiver.

10. If I take Children’s Choice and my child’s name comes up for DD Waiver services on the DD RFSR before he/she reaches age twenty-one (21) can I transfer to the NOW?
No, families must choose either to accept a slot in the Children’s Choice Waiver or to remain on the DDRFSR. This is an individual decision based on a family’s current circumstances. A family who chooses Children’s Choice may later experience a crisis in circumstances that increases the need for paid supports to a level that cannot be accommodated within the cap on waiver expenditures. At that time a crisis -crisis designation request can be made.

11. If a crisis occurs and additional services are needed beyond the cap, how long will it take to access those services?
When the crisis occurs, the family should contact the support coordination agency to convene the team to evaluate the need and to request approval of the needed services. After all documentation is prepared and sufficient evidence of the need is presented to the State Office Review Committee an urgent request can be approved within two days.
12. What happens when my child reaches age twenty-one (21) and Children's Choice benefits expire?
Once your child turns age twenty-one (21), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult waiver. Approximately ninety (90) days before your child turns twenty-one (21), this eligibility and transfer process would begin.

13. I've been told that some of the $16,410 is used for mandatory support coordination. Can I forgo these services and instead use these funds to purchase additional community-based services?
No, support coordination is a Children's Choice Waiver service. The support coordination agency is responsible for development of the comprehensive plan of care and assuring the services your child needs are delivered. However, LDH/OCDD will continue to seek ways to make the support coordination requirement more flexible.

14. Are there any other services under Children's Choice that families/children are required to take or use in a specific amount of funding?
No. There are no other "required" services under Children's Choice.

15. How do I choose a support coordination agency?
Support Coordination agencies are selected from a "Freedom of Choice" list. This list is sent at the same time a Children's Choice Waiver offer is sent to the family.

17. Can families who accept Children's Choice for their child receive the funding directly, or through a fiscal intermediary, so they can recruit, hire or fire the in-home supporters? Families can't receive the funding directly, but they can hire workers directly and have them paid through a fiscal intermediary that has a contract with the State. This is called the Self-directed option.

18. How long does it take to get services once my child has been determined to be eligible?
The process works as follows:
1) The family accepts Children's Choice Services
2) A support coordinator is chosen and development of a Plan of Care (POC) begins
3) The child is determined eligible for the Children's Choice Waiver; and
4) The POC is approved.
The support coordinator then begins to implement the POC and arrange other necessary services.

19. How often is our family required to get an eligibility determination?
Re-certification is required annually, and the POC is renewed annually as well.

20. I've been told that the service limit cap of $16,410 per year represents a decrease. Is this true?
Yes. The Department of Health (LDH) raised the yearly cap from $7,500 to $15,000 to $17,000 per plan-of-care-year and as a result of a budgetary shortfall service cap was decreased to $16,410.

21. If I have concerns about my service provider(s) or support coordinator, who should I call?
Call the OCDD toll-free help line at 1-866-783-5553.

22. If I accept Children's Choice, how will that affect the services I am receiving from other programs?
Regarding state funded programs, it is a case-by-case decision as to whether there would be an effect.

23. Can a family "stockpile" time for family supports such as respite or family support for use during holidays or summer vacation?
The Plan of Care (POC) determines the number of service hours a recipient can receive based on the individuals need. The POC should be flexible to meet the individual's needs, and if one's needs change, the POC can change, thus allowing the individual flexibility.
24. Will accepting Children's Choice affect my child's Supplemental Security Income (SSI) or the Medicaid services he receives now? This acceptance should have no effect on other Medicaid state plan services. Accepting Children's Choice has no effect of SSI eligibility.

25. What is considered "direct care"? Direct Care the provision of services to a patient that require some degree of interaction between the patient and the health care provider

Direct care can be services and supports provided in a direct manner to the individual.

26. Will my waiver services be affected if I choose to opt into a Medicaid Healthy Louisiana plan? Participation in a Healthy Louisiana plan will have no effect on how you will receive your waiver services.
Frequently Asked Children’s Choice Questions

1. What is Children’s Choice?
Children's Choice is a program designed to help families who provide in-home care and support for their children with developmental disabilities. Children's Choice assists by providing funding for medical care, home modifications, care-giving assistance and support, and other specialty services. Children's Choice is a support program designed to be flexible enough to let families choose when they need the covered services.

Children's Choice is intended to supplement the care and support that eligible children already receive at home, through their extended families or that is already available within local communities. Funds available through Children's Choice are capped at $16,410 per care plan year. Recipients are also eligible for services through the Medicaid State Plan which includes all medically necessary services.

2. What are the eligibility requirements for Children's Choice?
- Child is on the Request for Services Registry.
- Child is under twenty-one (21) years of age.
- Child is disabled according to SSI criteria.
- Child requires the level of care provided in an ICF/DD facility (institution).
- Child has income less than three (3) times the SSI amount.
- Child has resources less than $2,000.
- Child meets all Medicaid non-financial requirements (citizenship, residence, Social Security number, etc.).
- Child's plan of care meets the health and welfare needs of the child.
- Appropriate level of care can be provided outside an institution.

3. What services are available through Children's Choice?
- Support Coordination
- Family Support
- Center-based Respite
- Environmental Accessibility Adaptations
- Family Training
- Specialized Medical Equipment and Supplies
- Therapy Services
- Aquatic Therapy
- Art Therapy
- Music Therapy
- Hippotherapy
- Therapeutic Horseback Riding
- Sensory Integration Therapy
- Housing Stabilization Transition Services
- Housing Stabilization
- Medical coverage via the Medicaid program

4. What are some of the things that would be covered by the Medicaid card?
When a child is certified for Children's Choice, they will be entitled to receive medical services and get a Medicaid card.

Some services include physician services, hospital services, Applied Behavioral Analysis-Based Therapy, home health, additional personal care services, durable medical equipment, pharmacy services and many others.

5. What is the New Opportunities Waiver (NOW)?
The NOW is a comprehensive community-based waiver program that serves both children and adults with developmental disabilities. Traditionally, Medicaid pays for and provides services for these individuals in
institutional settings. Through the waiver program, citizens with developmental disabilities have greater flexibility to choose where they want to live, and the services and supports that best suit their needs, while still receiving Medicaid benefits.

The NOW pays for services such as personal care attendants, environmental modifications, assistive devices, respite care and many other services. In addition, day/vocational services and residential alternatives (such as supervised independent living and extended family living) are provided.

6. How can a parent find out what their child’s request date is on the Request for Services Registry?
A parent can call Toll Free 1-866-783-5553 or contact their Human Services Authorities or Districts to obtain their child’s request date and Screening for Urgency of Need (SUN) score. The Registry Date that is currently being served can be accessed at the OCDD Request for Services Registry web page at http://new.dhh.louisiana.gov/index.cfm/page/136/n/138

7. How often are the opportunity letters offering Children’s Choice to families sent out and will families who initially declined Children’s Choice be contacted again in the future to see if they have changed their mind, especially if there are changes in the program?
When Children’s Choice opportunities are available, letters go out to families. Families who have initially said "no" will not be offered a Children’s Choice Waiver opportunity again. Their names will be removed from the Developmental Disabilities Request for Services Registry (DD RFDSR). Once a recipient's name has been removed from DD Request for Service Registry the individual/family will have to start over again by contacting their Human Services Authorities or Districts to complete the screening process.

8. What if I think my child needs more services in excess of the yearly limit?
Children’s Choice is designed for children under age twenty-one (21) with low to moderate needs and whose families provide most of the care and support. But if a crisis situation develops and additional supports are warranted, there are crisis provisions designed to meet the needs of families on a case-by-case basis.

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If a child’s needs significantly change and a crisis designation is met, the child’s name would be returned to the Request for Services Registry with the child's original request date. Additionally, once your child turns age twenty-one (21), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult Waiver.

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No, families must choose either to accept a slot in the Children’s Choice Waiver or to remain on the DDRFSR. This is an individual decision based on a family’s current circumstances. A family who chooses Children’s Choice may later experience a crisis in circumstances that increases the need for paid supports to a level that cannot be accommodated within the cap on waiver expenditures. At that time a crisis -crisis designation request can be made.

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Once your child turns age twenty-one (21), and continues to meet the eligibility criteria, your child would transfer to an appropriate adult waiver. Approximately ninety (90) days before your child turns twenty-one (21), this eligibility and transfer process would begin.

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No, support coordination is a Children’s Choice Waiver service. The support coordination agency is responsible for development of the comprehensive plan of care and assuring the services your child needs are delivered. However, LDH/OCDD will continue to seek ways to make the support coordination requirement more flexible.

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No. There are no other “required” services under Children’s Choice.

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Support Coordination agencies are selected from a “Freedom of Choice” list. This list is sent at the same time a Children's Choice Waiver offer is sent to the family.

17. Can families who accept Children’s Choice for their child receive the funding directly, or through a fiscal intermediary, so they can recruit, hire or fire the in-home supporters? Families can’t receive the funding directly, but they can hire workers directly and have them paid through a fiscal intermediary that has a contract with the State. This is called the Self-directed option.

18. How long does it take to get services once my child has been determined to be eligible?
The process works as follows:
1) The family accepts Children’s Choice Services
2) A support coordinator is chosen and development of a Plan of Care (POC) begins
3) The child is determined eligible for the Children's Choice Waiver; and
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Regarding state funded programs, it is a case-by-case decision as to whether there would be an effect.

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The Plan of Care (POC) determines the number of service hours a recipient can receive based on the individuals need. The POC should be flexible to meet the individual's needs, and if one's needs change, the POC can change, thus allowing the individual flexibility.
24. Will accepting Children’s Choice affect my child’s Supplemental Security Income (SSI) or the Medicaid services he receives now?
This acceptance should have no effect on other Medicaid state plan services. Accepting Children’s Choice has no effect of SSI eligibility.

25. What is considered “direct care”? Direct Care the provision of services to a patient that require some degree of interaction between the patient and the health care provider

Direct care can be services and supports provided in a direct manner to the individual.

26. Will my waiver services be affected if I choose to opt into a Medicaid Healthy Louisiana plan?
Participation in a Healthy Louisiana plan will have no effect on how you will receive your waiver services.
New Opportunities Waiver Fact Sheet

WHAT IS THE NEW OPPORTUNITIES WAIVER?

The New Opportunities Waiver (NOW) program provides services in the home and in the community to individuals 3 years of age or older who are eligible to receive OCDD waiver services.

The NOW is intended to provide specific activity-focused services rather than continuous custodial care.

IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

<table>
<thead>
<tr>
<th>Individual and Family Support (IFS) for Day, Night, Shared</th>
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<tbody>
<tr>
<td>o Can be Self-Directed</td>
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<tr>
<td>Center-Based Respite</td>
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<tr>
<td>Community Integration and Development</td>
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<tr>
<td>Environmental Adaptations</td>
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<td>Specialized Medical Equipment</td>
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<td>Supported Employment and Transportation</td>
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<td>Prevocational Services</td>
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<tr>
<td>Personal Emergency Response</td>
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<td>Skilled Nursing</td>
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<td>One time transitional services</td>
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<tr>
<td>Housing Stabilization Transition</td>
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<tr>
<td>Housing Stabilization</td>
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</tbody>
</table>

*Individuals will receive Support Coordination services via state plan.*

*Individuals who receive the NOW may NOT receive LT-PCS services.*

WHO CAN QUALIFY FOR SERVICES?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), **AND**
- Have an OCDD Statement of Approval **AND**
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria **AND**
- Are 3 years of age or older, **AND**
- Whose needs cannot be met in another OCDD waiver
WHAT ARE THE CURRENT RESOURCE LIMITS?

Resources are the things people own. When we count resources for this program, we do not count the person’s home, the car they drive to medical appointments or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

WHAT ARE THE CURRENT MONTHLY INCOME LIMITS?

The income limits (also known as Special Income Limit (SIL)) are $2,250 for an individual and $4,500 for a couple (when both spouses need long-term care).

However, there is a “Waiver Spend-down” option which allows your eligibility to be considered even if your income is over the limit. Waiver Spend-down has a standard $20 income deduction. $65 and ½ of the remainder is also deducted from all earned income.

After the income deductions are applied, the average monthly waiver rate and other allowable incurred medical expenses are used to “spend-down” an individual’s excess income, qualifying the individual for Waiver. Allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance, or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party.

The individual’s liability is based on their income after the income deductions are applied. All individuals are allowed to retain a basic needs allowance from his/her income which is equal to $2,250 and the amount of incurred medical expenses not paid by a third party. Any remainder will be the individual’s liability for the cost of care in Waiver Spend-down.
**HOW CAN PEOPLE REQUEST AN OCDD WAIVER?**

OCDD's four developmental disability home and community-based waivers, New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver, and Children's Choice Waiver have implemented a tiered waiver system of service delivery, which will allow for individuals to be supported in the most appropriate waiver. Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their Request for Services Registry Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

OCDD maintains a Developmental Disability Request for Services Registry (RFSR) of individuals who have a need for waiver services along with the date the person initially requested waiver services.

As each individual is added to the RFSR, the individual is screened to determine their urgency of need for services. An individual, who meets the eligibility criteria, is in the highest urgency priority category(s) being served based on funding, and has the earliest RFSR date, will be offered the next available OCDD waiver opportunity that meets their needs.

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.
WHAT IS THE CHILDREN’S CHOICE WAIVER?

The Children’s Choice Waiver (CC) program provides services in the home and in the community to individuals 0 through 20 years of age, who currently live at home with their families or who will leave an institution to return home.

This waiver provides an individualized support package with a maximum cost of $16,410 per year, and is designed for maximum flexibility.

Youth who reach the age of 18 and want to work may choose to transition to a Supports Waiver as long as they remain eligible for waiver services.

Youth who continue in the Children’s Choice Waiver beyond age 18 will age out of Children’s Choice Waiver when they reach their 21st birthday. They will transition to the most appropriate waiver that meets their needs as long as they remain eligible for waiver services.

This program is not intended to provide 24 hours a day support.

IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

<table>
<thead>
<tr>
<th>Support Coordination</th>
<th>Therapy Services</th>
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<tbody>
<tr>
<td>Family Support</td>
<td>• Aquatic Therapy</td>
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<td>Crisis Support</td>
<td>• Art Therapy</td>
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<td>Center-Based Respite</td>
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<td>Family Training</td>
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<td>Environmental Accessibility Adaptions</td>
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<tr>
<td>Specialized Medical Equipment</td>
<td><em>Individuals who receive the CC Waiver may also receive EPSDT services.</em></td>
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<tr>
<td>Permanent Supportive Housing Stabilization</td>
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<tr>
<td>Permanent Supportive Housing Stabilization Transition</td>
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</table>
WHO CAN QUALIFY FOR SERVICES?

Individuals who:
- Meet Louisiana Medicaid eligibility AND
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), AND
- Have an OCDD Statement of Approval AND
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria AND
- Are 0 through 20 years of age

WHAT ARE THE CURRENT RESOURCE LIMITS?

Resources are the things people own. When we count resources for this program, we do not count the person’s home, the car they drive to medical appointments or other basic resources.
- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

WHAT ARE THE CURRENT MONTHLY INCOME LIMITS?

The income limits (also known as Special Income Limit (SIL)) are $2,250 for an individual and $4,500 for a couple (when both spouses need long-term care).

However, there is a “Waiver Spend-down” option, which allows your eligibility to be considered even if your income is over the limit. Waiver Spend-down has a standard $20 income deduction. $65 and ½ of the remainder is also deducted from all earned income.

After the income deductions are applied, the average monthly waiver rate and other allowable incurred medical expenses are used to “spend-down” an individual’s excess income, qualifying the individual for Waiver. Allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance, or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party.

The individual’s liability is based on their income after the income deductions are applied. All individuals are allowed to retain a basic needs allowance from his/her income which is equal to $2,250 and the amount of incurred medical expenses not paid by a third party. Any remainder will be the individual’s liability for the cost of care in Waiver Spend-down.
HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

OCDD's four developmental disability home and community-based waivers, New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver, and Children's Choice Waiver have implemented a tiered waiver system of service delivery, which will allow individuals to be supported in the most appropriate waiver. Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their Request for Services Registry Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

OCDD maintains a Developmental Disability Request for Services Registry (RFSR) of individuals who have a need for waiver services along with the date the person initially requested waiver services.

As each individual is added to the RFSR, the individual is screened to determine their urgency of need for services. An individual, who meets the eligibility criteria, is in the highest urgency priority category(s) being served based on funding, and has the earliest RFSR date, will be offered the next available OCDD waiver opportunity that meets their needs.

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.
# Supports Waiver Fact Sheet

## WHAT IS THE SUPPORTS WAIVER?

The Supports Waiver (SW) program provides services in the home and in the community to individuals 18 years of age or older, who are eligible to receive OCDD waiver services.

This program is not intended to provide 24 hours a day support.

## IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?

<table>
<thead>
<tr>
<th>Services</th>
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</thead>
<tbody>
<tr>
<td>Support Coordination</td>
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<td>Supported Employment</td>
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<td>Individual or Group</td>
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<td>Day Habilitation</td>
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<td>Prevocational</td>
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<tr>
<td>Habilitation</td>
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<td>Respite (center-based or in-home)</td>
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<td>Permanent Supportive Housing Stabilization</td>
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<td>Permanent Supportive Housing Stabilization Transition</td>
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<tr>
<td>Personal Emergency Response System (PERS)</td>
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</tbody>
</table>

*Individuals under 21 years of age may access Early Periodic Screening and Diagnostic Treatment (ESPDT) services

*Individuals who receive the SW may also receive Long Term Personal Care Services (LTPCS)

## WHO CAN QUALIFY FOR SERVICES?

Individuals who:

- Meet Louisiana Medicaid eligibility **AND**
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), **AND**
- Have an OCDD Statement of Approval **AND**
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria AND
- Are 18 years of age or older

**WHAT ARE THE CURRENT RESOURCE LIMITS?**

Resources are the things people own. When we count resources for this program, we do not count the person’s home, the car they drive to medical appointments or other basic resources.

- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

**WHAT ARE THE CURRENT MONTHLY INCOME LIMITS?**

The income limits (also known as Special Income Limit (SIL)) are $2,250 for an individual and $4,500 for a couple (when both spouses need long-term care).

However, there is a “Waiver Spend-down” option which allows your eligibility to be considered even if your income is over the limit. Waiver Spend-down has a standard $20 income deduction. $65 and ½ of the remainder is also deducted from all earned income.

After the income deductions are applied, the average monthly waiver rate and other allowable incurred medical expenses are used to “spend-down” an individual’s excess income, qualifying the individual for Waiver. Allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance, or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party.

The individual’s liability is based on their income after the income deductions are applied. All individuals are allowed to retain a basic needs allowance from his/her income which is equal to $2,250 and the amount of incurred medical expenses not paid by a third party. Any remainder will be the individual’s liability for the cost of care in Waiver Spend-down.
HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

OCDD's four developmental disability home and community-based waivers, New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver, and Children's Choice Waiver have now been operationalized to a tiered waiver system of service delivery, which will allow for individuals to be supported in the most appropriate waiver. Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their RFSR Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

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OCDD maintains a Developmental Disability Request for Services Registry (RFSR) of individuals who have a need for waiver services along with the date the person initially requested waiver services.

As each individual is added to the RFSR, the individual is screened to determine their urgency of need for services. An individual, who meets the eligibility criteria, is in the highest urgency priority category(s) being served based on funding, and has the earliest RFSR date, will be offered the next available OCDD waiver opportunity that meets their needs.

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Residential Options Waiver (ROW) Fact Sheet

**WHAT IS THE RESIDENTIAL OPTIONS WAIVER (ROW)?**

The Residential Options Waiver (ROW) program provides services in the home and in the community to individuals of all ages who are eligible to receive OCDD waiver services. It is a capped waiver where the person's individual annual budget is based upon the person's assessed support needs. Supports needs are determined by an Inventory for Client and Agency Planning (ICAP) assessment.

This program is not intended to provide 24 hours a day of one to one support.

**IF I QUALIFY, WHAT SERVICES MAY I RECEIVE FROM THIS PROGRAM?**

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<thead>
<tr>
<th>Services Provided</th>
<th>Services Not Provided</th>
</tr>
</thead>
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<tr>
<td>- Support Coordination</td>
<td>- Assistive Technology/Specialized Medical Equipment and Supplies</td>
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<tr>
<td>- Community Living Supports</td>
<td>- Transportation-Community Access</td>
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<tr>
<td>- Host Home Services</td>
<td>- Professional Services</td>
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<td>- Companion Care Services</td>
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<td>- Shared Living</td>
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<td>- Adult Day Health Care</td>
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<td>- Respite Care-Out of Home</td>
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<td>- Personal Emergency Response System</td>
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<td>- One Time Transition Services</td>
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<td>- Environmental Accessibility Adaptations</td>
<td>- Housing Stabilization Transition Services</td>
</tr>
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*Individuals under 21 years of age must access Early Periodic Screening and Diagnostic Treatment (ESPDT) services.*

*Individuals who receive the ROW may NOT receive Long Term - Personal Care Services (LT-PCS) when in this program.*
WHO CAN QUALIFY FOR SERVICES?

Individuals who:
- Meet Louisiana Medicaid eligibility AND
- Meet the Louisiana definition for developmental disability which manifested prior to age 22 (Revised Statute 25:451.2, Paragraph (11)), AND
- Have an OCDD Statement of Approval AND
- Meet Intermediate Care Facility- Intellectual Disability (ICF-ID) Level of Care Criteria AND
- Meets one of four ROW priority group criteria

WHAT ARE THE CURRENT RESOURCE LIMITS?

Resources are the things people own. When we count resources for this program, we do not count the person’s home, the car they drive to medical appointments or other basic resources.
- Single people can have no more than $2,000 in resources. Couples can have no more than $3,000 in resources (when both spouses receive long-term care).

WHAT ARE THE CURRENT MONTHLY INCOME LIMITS?

The income limits (also known as Special Income Limit (SIL)) are $2,250 for an individual and $4,500 for a couple (when both spouses need long-term care).

However, there is a “Waiver Spend-down” option which allows your eligibility to be considered even if your income is over the limit. Waiver Spend-down has a standard $20 income deduction. $65 and ½ of the remainder is also deducted from all earned income.

After the income deductions are applied, the average monthly waiver rate and other allowable incurred medical expenses are used to “spend-down” an individual’s excess income, qualifying the individual for Waiver. Allowable incurred medical expenses include Medicare and private health insurance premiums, deductibles, coinsurance, or copayment charges, and medical/remedial care expenses incurred by an individual that are not subject to payment by a third party.

The individual’s liability is based on their income after the income deductions are applied. All individuals are allowed to retain a basic needs allowance from his/her income which is equal to $2,250 and the amount of incurred medical expenses not paid by a third party. Any remainder will be the individual’s liability for the cost of care in Waiver Spend-down.
HOW CAN PEOPLE REQUEST AN OCDD WAIVER?

OCDD's four developmental disability home and community-based waivers, New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver, and Children's Choice Waiver have now been operationalized to a tiered waiver system of service delivery, which will allow for individuals to be supported in the most appropriate waiver. Home and community-based waiver opportunities will now be provided based on the individual's prioritized need for support, which was identified in their RFSR Screening for Urgency of Need. Instead of being first come, first served, individuals with the most emergent and urgent need for support will have priority.

Individuals who have a need for services should contact their local Human Services District/Authority in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR).

OCDD maintains a Developmental Disability Request for Services Registry (RFSR) of individuals who have a need for waiver services along with the date the person initially requested waiver services.

As each individual is added to the RFSR, the individual is screened to determine their urgency of need for services. An individual, who meets the eligibility criteria, is in the highest urgency priority category(s) being served based on funding, and has the earliest RFSR date, will be offered the next available OCDD waiver opportunity that meets their needs.

To add your name to the Developmental Disability Request for Services Registry or if you have questions, you can contact the Human Services District/Authority for your area. Listed below is a web link to this information:

http://ldh.la.gov/index.cfm/page/134

If you do not have access to a computer, you may call the OCDD State Office at 866-783-5553 to request the contact information for your local Human Services District/Authority.
### Fee for Service
EPSDT Personal Care Services vs. Home Health Services
(including Extended Skilled Nursing Services also known as Extended Home Health)

<table>
<thead>
<tr>
<th>EPSDT Personal Care Services (PCS)</th>
<th>Home Health (Basic and Extended)</th>
</tr>
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<tbody>
<tr>
<td>Services include: basic personal care – bathing, dressing and grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores for the recipient only.</td>
<td>Basic Home Health Services for recipients under 21 include skilled nurse visits (RN or LPN) and Home Health Aide visits. If these visits are for less than 3 hours per day, they do not require prior authorization. Physical Therapy, Occupational Therapy and Speech Therapy provided by a home health agency must be prior authorized.</td>
</tr>
<tr>
<td>Does not cover any medical tasks, medication administration, or NG tube feeding.</td>
<td>Recipients may also receive Extended Skilled Nursing Services (Extended HH) which is <strong>three of more hours per day</strong>, several days per week for an extended period of time. Can provide medical tasks such as tube feeding, catheter maintenance and medication administration.</td>
</tr>
<tr>
<td>Accompanying, NOT TRANSPORTING recipients to medical appointments.</td>
<td>Extended Skilled Nursing Services (Extended HH) and all therapies must be prior authorized. Home Health visits above one per day must be prior authorized by BHSF/Molina for participants with Legacy Medicaid and by the Healthy Louisiana Plan for participants with Healthy Louisiana for their physical health services. Documentation that must accompany HH request: Physician referral on letterhead, home health plan of care, and a completed PA-07.</td>
</tr>
<tr>
<td>EPSDT PCS is not to function as a substitute for childcare arrangements or to provide respite care to the primary caregiver.</td>
<td>Children may still be eligible for Extended Skilled Nursing Services even if they attend school outside the home.</td>
</tr>
<tr>
<td>Must be prior authorized by BHSF/Molina for participants with Legacy Medicaid and by the Healthy Louisiana Plan for participants with Healthy Louisiana for their physical health services. Documentation that must accompany PCS request: PA-14, Daily Time Schedule, EPSDT-PCS Form 90, Plan of care approved by the physician, Social Assessment and any supporting documentation.</td>
<td>For Extended Services, a prescription is needed from the doctor stating the number of hours requested and a letter of medical necessity justifying the reason for extended services and the number of hours requested.</td>
</tr>
<tr>
<td>Ages: birth through 20</td>
<td>Therapies can be provided by Home Health agencies, an outpatient facility, in an Early Intervention Center, rehabilitation center and at school.</td>
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<tr>
<td>Services provided by a Medicaid enrolled Personal Care Services provider.</td>
<td></td>
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 Issued 7/27/06
Revised 6/3/13, 6/16/14, 4/2/15, 5/3/16, 4/27/17, 5/11/18, 4/24/19
**Early Periodic Screening, Diagnosis and Treatment Personal Care Services**

1. Tasks that are medically necessary as they pertain to an EPSDT eligible recipient’s physical requirements when cognitive or physical limitations necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.

2. Services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

**Recipient Qualifications**

Conditions for Provision of EPSDT Personal Care Services

1. The person must be a categorically –eligible Medicaid recipient birth through 20 years of age (EPSDT eligible) **and have been prescribed EPSDT PCS as medically necessary by a physician.** To establish medical necessity the parent or guardian must be physically unable to provide personal care services to the child.

2. When determining whether a recipient qualifies for EPSDT PCS, **consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. EPSDT PCS are not to function as a substitute for childcare arrangements.** A parent or adult caregiver is **no longer required** to be in the home while services are being provided to children age 14 or younger.

3. EPSDT personal care services **must be prescribed by the recipients attending physician initially and every 180 days thereafter (or rolling six months), and when changes in the Plan of Care occur.** The physician should only sign a fully completed plan of care which shall be acceptable for submission to BHSF only after the physician signs and dates the form. The physician's signature must be an original signature and not a rubber stamp.

**Place of Service**

EPSDT personal care services must be provided in the **recipient’s home** or in another location if medically necessary to be outside of the recipient's home.

**Services**

EPSDT personal care services include:

1. basic personal care, toileting and grooming activities, including bathing, care of the hair, and assistance with clothing;

2. assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization

3. assistance with eating and food, nutrition, and diet activities, including preparation of meals for the recipient **only**;

4. performance of incidental household services essential to the clients health and comfort in her/his home. Examples of such activities are changing and washing bed linens and rearranging furniture to enable the recipient to move about more easily in his/her own home;

5. accompanying not transporting the recipient to and from his/her physician and/or medical facility for necessary medical services;

6. EPSDT personal care services are not to be provided to meet childcare needs nor as a substitute for the parent in the absence of the parent;

7. personal care services (PCS) are not allowable for the purpose of providing respite care to the primary caregiver;

8. EPSDT personal care services provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or must be provided by the Department of Education;

**Nonreimbursable Services**

- custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task;

- EPSDT personal care services provided to meet childcare needs or as a substitute for the parent in the absence of the parent shall not be reimbursed.

Issued June 2009

Mandatory Training

Revised 10/28/10, 2/9/12, 6/16/14, 4/30/15, 4/24/19
- EPSDT personal care services provided for the purpose of providing respite to the primary caregiver shall not be reimbursed.

**Provider Qualifications**

A. Personal care services must be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. **Staff assigned to provide personal care services shall not be a member of the recipient's immediate family.** (Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient). Personal care services may be provided by a person of a degree of relationship to the recipient other than immediate family, if the relative is not living in the recipient's home, or, if she/he is living in the recipient's home solely because her/his presence in the home is necessitated by the amount of care required by the recipient.
Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

- Doctor’s Visits
- Hospital (inpatient and outpatient) Services
- Lab and X-ray Tests
- Family Planning
- Home Health Care
- Dental Care
- Rehabilitation Services
- Prescription Drugs
- Medical Equipment, Appliances and Supplies (DME)
- Support Coordination
- Speech and Language Evaluations and Therapies
- Occupational Therapy
- Physical Therapy
- Psychological Evaluations and Therapy*
- Psychological and Behavior Services*
- Podiatry Services
- Optometrist Services
- Hospice Services
- Certified Nurse Practitioners
- Residential Institutional Care or Home and Community Based (Waiver) Services
- Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
- Immunizations
- Applied Behavioral Analysis
- Eyeglasses
- Hearing Aids
- Psychiatric Hospital Care*
- Personal Care Services
- Audiological Services
- Necessary Transportation: Ambulance Transportation
- Non-ambulance Transportation*
- Appointment Scheduling Assistance
- Substance Abuse Clinic Services
- Chiropractic Services
- Prenatal Care
- Certified Nurse Midwives
- Extended Skilled Nurse Services
- Mental Health Clinic Services*
- Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
- Ambulatory Surgery Services
- Developmental and Behavioral Clinic Services
- Early Intervention Services
- Nursing Facility Services
- Prenatal Care Services
- Sexually Transmitted Disease Screening
- Pediatric Day Health Care
- and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

*All specialized behavioral health services and non-emergency medical transportation services are accessed through your Medicaid Managed Care Program. Contact numbers for the Managed Care Organizations are below. If the recipient is enrolled in the Coordinated System of Care (CSoC) all specialized behavioral health services will be accessed through Magellan. Magellan can be reached at 1-800-434-4489.

To access specialized behavioral health contact your Managed Care Organization at:

<table>
<thead>
<tr>
<th>Managed Care Organization</th>
<th>Contact Number</th>
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</thead>
<tbody>
<tr>
<td>Aetna Better Health</td>
<td>1-855-242-0802</td>
</tr>
<tr>
<td>AmeriHealth Caritas Louisiana</td>
<td>1-888-756-0004</td>
</tr>
<tr>
<td>Healthy Blue</td>
<td>1-844-521-6941</td>
</tr>
<tr>
<td>Louisiana Healthcare Connections</td>
<td>1-866-595-8133</td>
</tr>
<tr>
<td>United Healthcare Community Plan</td>
<td>1-866-675-1607</td>
</tr>
</tbody>
</table>
To access non-emergency medical transportation contact your Managed Care Organization at:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health</td>
<td>1-877-917-4150</td>
</tr>
<tr>
<td>AmeriHealth Caritas Louisiana</td>
<td>1-888-325-7565</td>
</tr>
<tr>
<td>Healthy Blue</td>
<td>1-866-430-1101</td>
</tr>
<tr>
<td>Louisiana Healthcare Connections</td>
<td>1-855-369-3723</td>
</tr>
<tr>
<td>United Healthcare Community Plan</td>
<td>1-866-726-1472</td>
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</table>

For participants with Legacy Medicaid for their physical health services, if you need a service that is not listed above you can call the referral assistance coordinator at SPECIALTY RESOURCE LINE (toll free) 1-877-455-9955. If they cannot refer you to a provider of the service you need call 225-342-5774.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, the SPECIALTY RESOURCE LINE can assist you or your medical provider with information as to which services must be pre-approved for recipients with Legacy Medicaid for their physical health services. For recipients with the Medicaid Managed Care Program for their physical health services contact the Managed Care Organization.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting the SPECIALTY RESOURCE LINE. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact the SPECIALTY RESOURCE LINE toll-free at 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or you may contact your physician directly to obtain an appointment for a screening visit if you already have a provider. If you have a communication disability or are non-English speaking, you may have someone else call the SPECIALTY RESOURCE LINE and the appropriate assistance can be provided. For recipients with the Medicaid Managed Care Program for their physical health services, contact the Managed Care Organization.

Louisiana Medicaid encourages you to contact the SPECIALTY RESOURCE LINE office and obtain a provider so that you may be better served.

Revised 3.13.19
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
HUMAN SERVICES DISTRICTS and AUTHORITIES

Metropolitan Human Services District
Donna Francis, DD  Dr. Rochelle Dunham, Ex. Dir.
3100 Gen de Gaulle Dr., New Orleans, LA 70114
Phone: (504) 568-3130 Fax: (504) 568-4660
Toll Free: 1-800-889-2975

Central Louisiana Human Services District
Paxton Oliver II DD Michael R DeCaire, PH.D Ex Dir
429 Murray St.-Ste B, Alexandria, LA 71301
Phone: (318) 484-2347 Fax (318) 484-2458
Toll Free: 1-800-640-7494

Orleans – Plaquemines – St. Bernard

Capital Area Human Services District
Kay Gaudet, DD  Jan Kasofsky, Ex. Dir.
4615 Government St. – Building 2, B.R., La. 70806
Phone: (225) 925-1910  Fax: (225) 925-1966
Toll Free: 1-866-628-2133

Avoyelles – Catahoula – Concordia – Grant
LaSalle – Rapides – Vernon – Winn

South Central La. Human Services Authority
Wesley Cagle, DD  Lisa Schilling, Ex. Dir.
5597 Hwy 311, Houma, LA 70360
Phone: (985) 876-8805  Fax: (985) 876-8905
Toll Free: 1-800-861-0241

Ascension – EBR – East Fel. – Iberville
Pointe Coupee – WBR – West Fel

Northwest Louisiana Human Services District
Sharon Doyle, DD  Doug Efferson, Ex Dir
3018 Old Minden Rd, Ste. 1211, Bossier City, LA 71112
Phone: (318) 741-7455 Fax: (318) 741-7445
Toll Free: 1-800-862-1409

Assumption – LaFourche – St. Charles – St. James
St. John – St. Mary – Terrebonne

Northeast Delta Human Services Authority
Jennifer Purvis, DD  Monteic Sizer, Ex Dir
2513 Ferrand St., Monroe, LA 71201
Phone: (318) 362-3396 Fax: (318) 362-5306
Toll Free: 1-800-637-3113

Acadiana Area Human Services District
Troy Abshire, DD  Brad Farmer, Ex Dir
302 Dulles Dr, Lafayette, LA 70506
Phone: (337) 262-5610  Fax: (337) 262-5233
Toll Free: 1-800-648-1484

Caldwell – East Carroll – Franklin –Jackson – Lincoln
Madison- Morehouse – Ouachita – Richland-
Tensas – Union – West Carroll

Imperial Calcasieu Human Services Authority
James Lewis, DD  Tanya McGee, Ex Dir
One Lakeshore Dr. Suite 2000 Lake Charles, LA 70629
Phone: (337) 475-3100  Fax: (337) 475-8055
Toll Free: 1-800-631-8810

Florida Parishes Human Services Authority
Janise Monetta, DD  Richard Kramer, Dir.
835 Pride Drive, Suite B, Hammond, LA 70401
Phone: (985) 543-4333  Fax: (985) 543-4817

Allen - Beauregard – Calcasieu – Cameron
Jefferson Davis

Jefferson Parish Human Services Authority
Nicole Green, DD  Lisa English Rhoden, Ex. Dir.
1500 River Oaks Rd. West, Ste. 200, Jefferson, LA 70123
Phone: (504) 838-5424  Fax: (504) 838-5400

Toll Free: 1-800-861-0241

Appendix G

Updated 2.11.19
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
Regional EPSDT Specialists

METROPOLITAN HUMAN SERVICES DISTRICT
Veronica Allen
3100 Gen de Gaulle Dr.
New Orleans, LA  70114
Phone: (504) 568-3130
FAX: (504) 568-4660
Toll Free: 1-800-889-2975

CENTRAL LOUISIANA COMMUNITY SERVICES DISTRICT
Lisa Fontenot
429 Murray Street – Suite B
Alexandria, LA  71301
Phone: (318) 484-2347
FAX: (318) 484-2458
Toll Free: 1-800-640-7494

CAPITAL AREA HUMAN SERVICES DISTRICT
Polly Rheams
4615 Government St. – Bldg. 2
Baton Rouge, LA  70806
Phone: (225) 925-1910
FAX: (225) 925-1966
Toll Free: 1-866-628-2133

NORTHWEST LOUISIANA HUMAN SERVICES DISTRICT
Nancy Howard
3018 Old Minden Road – Suite 1211
Bossier City, LA  71112
Phone: (318) 741-7455
FAX: (318) 741-7445
Toll Free: 1-800-862-1409

SOUTH CENTRAL LOUISIANA HUMAN SERVICES AUTHORITY
Freda Green and Raymond Menard
5593 Hwy 311
Houma, LA  70360
Phone: (985) 876-8805
FAX: (985) 449-5180
Toll Free: 1-800-861-0241

NORTHEAST DELTA HUMAN SERVICES AUTHORITY
Emily Burns
3200 Concordia Avenue
Monroe, LA  71201
Phone: (318) 362-5188
FAX: (318) 362-5215
Toll Free: 1-800-637-3113

ACADIANA AREA HUMAN SERVICES DISTRICT - Updated
Tina Lyons
302 Dulles Dr
Lafayette, LA  70506
Phone (337) 262-5610
FAX: (337) 262-5233
Toll Free: 1-800-648-1484

FLORIDA PARISHES HUMAN SERVICES AUTHORITY
Crystal Parker and Lori Carter
835 Pride Drive, Suite B
Hammond, LA  70401
Phone: (985) 543-4333
FAX: (985) 543-4817

IMPERIAL CALCASIEU HUMAN SERVICES AUTHORITY
Doanie Perry
One Lakeshore Dr. Suite 2000
Lake Charles, LA  70629
Phone: (337) 475-3100
FAX: (337) 475-8055
Toll Free: 1-800-631-8810

JEFFERSON PARISH HUMAN SERVICES AUTHORITY
Reion Janeau
1500 River Oaks Rd. West, Suite 200
Jefferson, LA  70123
Phone (504) 838-5424
FAX: (504) 838-5400

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Acadia – Evangeline – Iberia – Lafayette
St. Landry – St. Martin – Vermilion

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Nicole Green, DD  Lisa English Rhoden, Ex. Dir.
1500 River Oaks Rd. West, Ste. 200, Jefferson, LA 70123
Phone: (504) 838-5424 Fax: (504) 838-5400

Updated 2.11.19
Past
- Prenatal Health
- Nature and cause of disability
- Age of diagnosis and made by whom
- Any early intervention
- Past medical history, surgeries, hospitalizations
- Any placement history outside of current placement
- Why is EPSDT SC being requested? If no services to coordinate is family aware SC is optional and declining will not affect their eligibility to receive Medicaid services or their placement on the Waiver registry?

Present
- Names and ages of household members
- Primary caregiver and natural supports
- Address both mom and dad and if they provide any natural or financial support
- Is the home owned or rented?
- Does the home environment meet their needs?
- Access to transportation and community
- Source of household income

Medical Diagnoses
- List all diagnoses and what documentation you have for each (ICD10 must have current documentation to support)
- If any diagnosis is “parent states” and you don’t have documentation to back it up address that and address what you’re doing to obtain documentation or if no documentation exists
- List all doctor’s names and specialties, how often they see them, last visit/next visit
- List all meds and what they are prescribed for
- Address special procedures - trach, g-tube, etc.
- Ambulation
- Communication
- Vison
- Hearing
- Toileting needs
- Dietary needs
- Do they need assistance with their ADLs? If so was PCS offered? If PCS is received, what ADLs do they need PCS to assist with?
- What therapies do they receive at school and were community therapies offered?

Psych/Behavioral
- Address behaviors at both home and school
- What behaviors do they have / what does it look like?
- How often does it occur?
- Any triggers?
- What strategies are used to deal with behaviors?
- What behavior services are received or offered?

Evaluation/Documentation
- Current formal document that was less than a year old at time of CPOC meeting
- Current IEP if Special Ed
- Current EHH Plan of Care if receiving EHH
- Current PDHC Plan of Care if receiving PDHC
- Current SOA or Redetermination as a service need

Service Needs
- List all school therapies
- List services that require PA tracking like PCS, EHH, PDHC, OT, PT, ST, DMEs, ABA, BHR, etc.
- List services requested from OCDD like Family Flexible Fund, respite, redetermination, family support, etc.
- List services that pertain to behavioral health like psychiatrist, behavioral meds, counseling, etc.
- List services requested through the community
- List Transition as a service need if will be 20.5 years old this CPOC year
- List Redetermination if their SOA will expire this CPOC year or is expired

Additional Info
- List chosen providers for each service
- If unclear what a service need is elaborate here
- If any services that typically require PA tracking are not checked as “requires PA tracking” document the valid reason for not tracking the service need
- If any service needs are marked as “Other – Explain Next Page”, document why the service need is on hold
- If any service needs are marked as “Carried Over - Resolved” or “Family Does Not Want” explain why
- If family is checked state why
Rights and Responsibilities for Applicants / Participants of EPSDT Targeted Support Coordination

These are your rights as an applicant for or a participant in EPSDT Targeted Support Coordination Services:

• To be treated with dignity and respect.
• To participate in and receive person-centered, individualized planning of supports and services.
• To receive accurate, complete, and timely information that includes a written explanation of the process of evaluation and participation in EPSDT Targeted Support Coordination Services including how you qualify for it and what to do if you are not satisfied.
• To work with competent, capable people in the system.
• To file a complaint, grievance, or appeal with a support coordination agency, direct service provider, or the Department of Health and Hospitals regarding services provided to you if you are dissatisfied. Please call Health Standards at 1-800-660-0488.
• To have a choice of service/support providers when there is a choice available.
• To receive services in a person-centered way from trained, competent care givers.
• To have timely access to all approved services identified in your Comprehensive Plan of Care (CPOC).
• To receive in writing any rules, regulations, or other changes that affect your participation in EPSDT Targeted Support Coordination Services.
• To receive information explaining support coordinator and direct service provider responsibilities and their requirements in providing services to you.
• To have all available Medicaid services explained to you and how to access them if you are a Medicaid recipient.
• To discontinue Support Coordination services at any time without discontinuance of the prior authorized Medicaid services which you are receiving or have requested; you may request to resume EPSDT Support Coordination Services at any time by calling Statistical Resources at 1-800-364-7828.
Appendix K

These are your **responsibilities** as an applicant for or participant of EPSDT Targeted Support Coordination Services:

- To actively participate in planning and making decisions on supports and services you need.
- To cooperate in planning for all the services and supports you will be receiving.
- To refuse to sign any paper that you do not understand or that is not complete.
- To provide all necessary information about yourself. This will help the support coordinator to develop a Comprehensive Plan of Care (CPOC) that will determine what services and supports you need.
- To not ask providers to do things in a way that are against the laws and procedures they are required to follow.
- To cooperate with Medicaid and your support coordinator by allowing them to contact you by phone and visit with you at least quarterly. Necessary visits include an initial in-home visit in order to gather information and complete an assessment of needs, regular quarterly visits at the location of your choice to assure your plan of care is sufficient to meet your needs, and visits resulting from complaints to BHSF.
- To immediately notify the support coordinator and direct service provider who works with you if your health, medications, service needs, address, phone number, alternate contact number, or your financial situation changes.
- To help the support coordinator to identify any natural and community supports that would be of assistance to you in meeting your needs.
- To follow the requirements of the program, and if information is not clear, ask the support coordinator or direct service provider to explain it to you.
- To verify you have received the medical services the provider says you have received, including the number of hours your direct care provider works, and report any differences to your support coordinator.
- To obtain assessment information /documentation requested by your support coordinator or service provider that is required for accessing the services that you are requesting, i.e. BHSF Form 90-L “Request for Level of Care Determination”, 1508 Evaluation/Update, IEP, etc.
- To understand that EPSDT Targeted Support Coordination Services have an age requirement and that support coordination services and some Medicaid services will be discontinued at the 21st birthday.
Responsibilities as an applicant for or participant of EPSDT Targeted Support Coordination Services (continued):

- To understand that you may request to discontinue Support Coordination services at any time without discontinuance of the prior authorized Medicaid services which you are receiving or have requested; to understand that you may request to resume EPSDT Support Coordination Services at any time by calling SRI at 1-800-364-7828.

I have read and understand my rights and responsibilities for applying for / participating in EPSDT Support Coordination Services. I also understand the reasons that Support Coordination Services may be discontinued for me or the person whom I am authorized to represent in this matter.

<table>
<thead>
<tr>
<th>Applicant/Participant Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signature of Applicant/Participant or Authorized Representative</strong></td>
<td><strong>Date</strong></td>
</tr>
<tr>
<td><strong>Support Coordinator</strong></td>
<td><strong>Date</strong></td>
</tr>
</tbody>
</table>
*All Legacy Medicaid appeals and MCO appeals after the MCO appeal process has been completed.

<table>
<thead>
<tr>
<th>Can I Appeal a Medicaid Decision?</th>
<th>How do I appeal?</th>
<th>Can my Support Coordinator help with my appeal?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, you have the right to appeal:</td>
<td>Send a written request for appeal to:</td>
<td><strong>YES!</strong> Your Support Coordinator should have received training to assist you with an appeal. He/she can help you gather the necessary information within the allotted time.</td>
</tr>
<tr>
<td>• If all the services you requested were denied</td>
<td>Director Division of Administrative Law Health and Hospitals Section P.O. Box 4189 Baton Rouge, LA 70821-4189 (fax) 225-219-9823</td>
<td><strong>What Deadlines Apply?</strong></td>
</tr>
<tr>
<td>• If part of the services you requested were denied</td>
<td>Or call: 225-342-5800 or 225-342-0443 <em>(Telephone appeals are allowed, but are not encouraged)</em></td>
<td>• The notice of denial will tell you when the appeal must be filed. You must appeal before or by that date.</td>
</tr>
<tr>
<td>• If you were offered different services than you requested</td>
<td>Or complete and submit the online Recipient Appeal Request form: <a href="http://www.adminlaw.state.la.us/forms.htm">www.adminlaw.state.la.us/forms.htm</a></td>
<td>• Appealing within 10 days of denial or before the services stop (whichever is longer) may keep services you are already receiving from being cut while the appeal is going on.</td>
</tr>
<tr>
<td>• If the service provider did not submit for full amount of services you requested. <em>(In this case, a doctor’s note showing the need for the requested services must be included with the appeal.)</em></td>
<td><strong>Do I Have to Get Another Doctor’s Statement?</strong></td>
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<tr>
<td></td>
<td>To win the appeal, you may need to get your doctor to give a statement with more details about why the services are needed. The doctor’s statement should include the number of hours of services needed.</td>
<td><strong>Can Someone Help me with the Appeal?</strong></td>
</tr>
<tr>
<td>Is There Anything Besides Appealing That I Can Do to Get Services?</td>
<td></td>
<td>You can have someone else represent your situation if you choose. That person can be a friend, relative, attorney or other spokesperson. The Advocacy Center (1-800-960-7705) helps with appeals.</td>
</tr>
</tbody>
</table>

The provider that sent in your request for services can request a reconsideration, with additional information. This must be done within 30 days of the denial. You will get a new decision, and if services are denied again, you can appeal then.

Or complete and submit the online Recipient Appeal Request form: [www.adminlaw.state.la.us/forms.htm](http://www.adminlaw.state.la.us/forms.htm)
Appendix L

*All Legacy Medicaid appeals and MCO appeals after the MCO appeal process has been completed.

APPEAL FORM

I want to appeal.

Name of Medicaid Recipient appealing: ____________________________.

Social Security Number of Medicaid Recipient: ________________________.

Would you like to request an expedited fair hearing?  ☐ Yes  ☐ No
If you have an emergency health issue, you can ask for a faster (expedited) fair hearing. If you request an expedited fair hearing, you may be contacted by the Louisiana Department of Health to provide proof of your emergency health.

Describe Items or Services requested (or enclose copy of denial notice):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of Recipient ___________________________ Date ______________________

Submit form to:

Division of Administrative Law
Health and Hospitals Section
P. O. Box 4189
Baton Rouge, LA 70821-4189
Fax: (225) 219-9823
Online: http://laserfiche.adminlaw.state.la.us/Forms/hSgLX

4.25.19
Department of Administrative Law Contact Info

Physical Address:
1020 Florida Street
Baton Rouge, LA 70802

Phone: 225-342-1800
Fax: 225-342-1812
E-mail: dhaddad@adminlaw.state.la.us
Website: [http://www.adminlaw.state.la.us/index.htm](http://www.adminlaw.state.la.us/index.htm)

Advocacy Center Contact Info

Main Office:
8325 Oak Street
New Orleans, LA 70118

Phone: 800-960-7705
E-mail: advocacycenter@advocacyla.org
Website: [www.advocacyla.org](http://www.advocacyla.org)
EPSDT TARGETED POPULATION  
PARTICIPANT COMPLAINT FORM

In order to better serve you, the Bureau of Health Services Financing would like to know if you have had any problems with the amount, kind and/or duration of services you received from your direct service provider and/or support coordinator. If you have experienced problems, please fill out this form and return it to:

Bureau of Health Services Financing – Health Standards  
P. O. Box 3767  
Baton Rouge, LA 70821-3767  

OR

You may call your complaint in to 1-800-660-0488

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

<table>
<thead>
<tr>
<th>Participant’s Name:</th>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>City / State / Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Person Reporting Complaint:</th>
<th>Phone Number (if different from participant):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I have a complaint with my:</th>
<th>Direct Service Provider/Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support Coordination Agency/Support Coordinator</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>Region:</th>
<th>Address:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>City / State / Zip:</th>
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<table>
<thead>
<tr>
<th>Name of Worker/Support Coordinator:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nature of Complaint:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Person Reporting Complaint:</th>
<th>Date:</th>
</tr>
</thead>
</table>
Sample SC FOC: Region number and list of available SC Agencies will vary from region to region.

SUPPORT COORDINATION CHOICE and RELEASE OF INFORMATION FORM
EPSDT Target Population  DHH Region 2

To the recipient: Please fill out Sections 1, 2 and 3 of this form and return it as soon as possible to:

Statistical Resources, Inc.  Case Management
11505 Perkins Road, Suite H
Baton Rouge, Louisiana 70810
Fax: (225) 767-0502

Recipient’s Name: ____________________________ Date of Birth: ______________
Physical Address: ______________________________ City: __________________________
State: _____ Zip code: _________ Telephone Number: (______) ______ - __________
Social Security Number: _____ - ____ - ______ Medicaid Number: _____________

Population: ☐ EPSDT Targeted Case Management
Recipient currently resides in a Group Home, Developmental Center, or Nursing Home? ☐ Yes ☐ No

Section 1: Support Coordination Freedom of Choice - DHH Region 2
The state has contracted with several support coordination providers in your area. Included with this letter are brochures describing the services of each agency. Please choose a provider from among these agencies. We ask that you number your choices. Please write 1 (one) in the box by your first choice and write 2 (two) in the box by your second choice. If your first choice is full, you will be linked to your second choice if they are not full. You will be linked for a 6-month period, after which you have the option of changing agencies if space is available.

☐ Medical Resources & Guidance
☐ Community Resource Coordinators

Signature of Recipient / Legal Guardian ____________________________ Date ______________

Section 2: Release of Information
I permit the release of any and all information which may be in the possession of DHH offices that pertain to my application(s) for services, including but not limited to OCDD statement of eligibility, OCDD Request for Services list, plans of support, generic service plans, doctor’s reports/evaluations, psychological reports/evaluations, medical/social/educational assessments of any kind, including those provided by schools, other agencies, and /or organizations. This includes all third party information which may be in DHH’s possession.

Signature of Recipient / Legal Guardian ____________________________ Date ______________

Section 3: Transfer of Records (For Agency Use Only)
Indicate which of the required documents have been transferred from the following agency:

☐ 1. Discharge 148  ☐ 4. 51NH  ☐ 7. Waiver slot letter (if not certified)  ☐ 10. Medical Documentation  ☐ 13. ____________________________
☐ 2. Form 142  ☐ 5. CPOC (current & approved)  ☐ 8. Social Evaluation  ☐ 11. IEP  ☐ 14. ____________________________

Signatures by both Transferring Agency and Receiving Agency are required for the Transfer of Records to be finalized.

Transferring Agency (Signature Required) ____________________________ Date ______________
Receiving Agency (Signature Required) ____________________________ Date ______________

STATISTICAL RESOURCES, INC. DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE RECIPIENT MEETS THE CRITERIA OF THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.
### Louisiana Department of Health & Hospitals
#### Comprehensive Plan of Care

**EPSDT - Targeted Support Coordination**

CPOC Type: ____ Annual, Initial, Interim

<table>
<thead>
<tr>
<th>Participant's Name:</th>
<th>Participant's DOB:</th>
<th>Region:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td>Guardian:</td>
<td></td>
</tr>
<tr>
<td>Medicaid Number:</td>
<td>Relationship:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Address (if different):</td>
<td></td>
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<tr>
<td>City/State/Zip:</td>
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<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Other Phone:</td>
<td></td>
</tr>
<tr>
<td>Support Coordination Agency:</td>
<td>Provider Number:</td>
<td></td>
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<tr>
<td>Support Coordination Agency's Address:</td>
<td>Contact Person:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Phone:</td>
<td></td>
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<tr>
<td>Healthy Louisiana Agency:</td>
<td></td>
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<tr>
<td>Healthy Louisiana Agency:</td>
<td>Healthy Louisiana Agency Phone:</td>
<td></td>
</tr>
</tbody>
</table>

**Sex:** 1. Male  2. Female


**Education:**
- 01 Early Intervention
- 02 Non-Categorical
- 03 Regular Kindergarten
- 04 Regular Education Only
- 05 Regular and Special Education
- 06 Special Education Only
- 07 Homebound Full Time
- 08 Graduated
- 09 Post-secondary: Collage
- 10 Post-secondary: Vocational
- 11 Pre-vocational Training
- 12 Supported Employment
- 13 Employed
- 14 Unemployed
- 15 Working toward GED
- 16 Home Schooled
- 98 N/A
- 99 Other

**Legal Status:**
- 1. Competent Major
- 2. Minor
- 3. Interdicted -- Full
- 4. Interdicted -- Limited
- 5. Tutorship
- 6. Commitment
- 7. Custody
- 8. O

**Is able to direct his/her own care:** Yes, No

**ID:** Mild, Moderate, Severe, Profound, Special Needs

**Adaptive Functioning:** Mild, Moderate, Severe, Profound, Special Needs

**Diagnosis Code (ICD9):**

**Residential Placement:**
- 01 Homeless
- 02 Incarcerated
- 03 Temporary Quarters
- 04 Nursing Home
- 05 ICF/DD with 16 or more beds
- 06 ICF/DD with 7 to 15 beds
- 07 Community Home with 6 or less beds
- 08 Supervised Apartment-OCDD Contract
- 09 Supported Living/Residential Habilitation
- 10 Subsiste Family Care
- 11 OCS Foster Care
- 12 Lives with Family/Friends
- 13 Lives Independently with Other
- 14 Lives Independently
- 15 Psychiatric Facility
- 16 General Medical Facility
- 99 Other

**Number of other individuals in home who are ID/DD/Special Needs who receive Medicaid Services:**

**Names:**

---

FOR LDH USE ONLY

CPOC Begin Date: | CPOC End Date:

Signature of DHH: | Date:
SECTION II: Medical/Social/Family History

PAST: Pertinent Historical Information: (date age and Cause of disability. If not known, put unknown. Placement situations that impact care; response to interventions in the past summary of events leading to request for services at this time.)

PRESENT: Describe Current Living Situation: (describe current family situation; identify all available natural supports; identify family’s understanding of individual’s situation/condition – knowledge of disability and consequences of non-compliance with CPOC; economic status; relevant social environmental and health factors that impact individual (i.e., health of care givers; home in rural/urban area; accessibility to resources; own home/rental/living with relatives/extended family or single family dwelling. Does home environment adequately meet the needs of individual or will environmental modifications be required ?)

HEALTH STATUS:

Physician Name: ____________________________________________

Date of Last Appointment: ________________________________

Immunizations Current: Yes No

Medical Diagnoses and Concerns/Significant Medical History: (Include findings of last physical)

Psychiatric/Behavioral Concerns:

Information included on this page is relevant to the individual’s life today and provides a means of sharing medical/social/family history not addressed in the content of the CPOC. Include information that is important to share and relevant to supporting and achieving the goals determined by the person.
<table>
<thead>
<tr>
<th>Service Strategy/ Descript</th>
<th>How was need determined?</th>
<th>Requested by participant/family</th>
<th>Why Not</th>
<th>Goal(s)</th>
<th>Receiving Service</th>
<th>Amount Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Serv</td>
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<tr>
<td>Extended Hme Serv</td>
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<td>DME</td>
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<td>OT</td>
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<td>Physical Therapy</td>
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<td>Speech Therapy</td>
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<td>Behavioral Health ReHab</td>
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<td>Dental Services</td>
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<td>Psch/Behav. Serv</td>
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<tr>
<td>Specialty Eyewear</td>
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<td>NEMT</td>
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<tr>
<td>Air Ambulance</td>
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<td>Out-of-State Care</td>
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<td>Organ Transplants</td>
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<tr>
<td>Diapers</td>
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<tr>
<td>School</td>
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<td>Vocational</td>
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<tr>
<td>Employment</td>
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<td>Transition</td>
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<tr>
<td>Pediatric Day H.C.</td>
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<tr>
<td>Applied Behavior Analysis</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

**Service Strategy List:**
Personal Care Serv, Extended Hme Serv, DME, OT, Physical Therapy, Speech Therapy, Behavioral Health ReHab, Dental Services, Psch/Behav. Serv, Specialty Eyewear, NEMT, Air Ambulance, Out-of-State Care, Organ Transplants, Diapers, School, Vocational, Employment, Transition, Pediatric Day H.C., Applied Behavior Analysis, Other

If the above has not been completed, the CPOC will be returned. All services requested shall be included and shall be re-addressed at each quarterly meeting.

**Participant/Guardian’s Signature:** ____________________________ **Date:** ____________

Additional Information about Service Needs and Supports:
SECTION V: CPOC PARTICIPANTS

<table>
<thead>
<tr>
<th>PLANNING PARTICIPANTS</th>
<th>TITLE &amp; AGENCY NAME</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies in addition to the therapies received at school through the IEP. Yes No

If not why not:

Support Coordinator has reviewed the Medicaid Services Chart with me: Yes No

If not why not:

Support Coordinator has provided me with information on Medicaid EPSDT Services: Yes No

If not why not:

Support Coordinator has provided me with information on EPSDT Screening Services: Yes No

If not why not:

EPSDT Screening Services requested:

I have reviewed and agree with the services contained in this plan. I understand it is my responsibility to notify the Support Coordinator of any change in my status which might affect the effectiveness of the services provided. I further agree to notify the Support Coordinator of any change in my income which might affect my child’s financial eligibility. I understand the services in this plan of care are not authorized by the Support Coordinator and the services may begin as soon as I am notified of their approval whether or not this plan of care has been approved.

_________ __________________
Participants/Guardian's Signature Date

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant's need and that that services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

_________ __________________
Support Coordinator's Signature Date

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required

_________ __________________
Support Coordinator Supervisor's Signature Date

SECTION VI: CARE PLAN ACTION

Participant Name: __________________ Date Approvable CPOC Rec'd by LDH: ________________

CPOC Status: __________________

Approval or denial of this CPOC does not approve or deny any of the services the participant may be eligible for, and only addresses the Support Coordinator's required services implementation and documentation.

Approved CPOC: Begin Date: ____________ End Date: __________________

Signature/Title of LDH Representative: ________________________________

Notes: ________________________________
### Section VI: Typical Weekly Schedule

For Planning Purposes Only. If needs change, I will contact my case manager as soon as possible.

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 AM</td>
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**CODE**

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<th>F = Family/Friends</th>
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<tr>
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<td>S = Self</td>
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<tr>
<td></td>
<td>Sc = School</td>
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<tr>
<td></td>
<td>ST = Speech Therapy</td>
</tr>
<tr>
<td></td>
<td>OT = Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>PCS = EPSDT Personal Care Services</td>
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<td></td>
<td>EHH = Extended Home Health</td>
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<td>PT = Physical Therapy</td>
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</table>

**COMMENTS:**

Above is the schedule of services requested by the individual and should be provided at these times. PCS can be provided at the same time as skilled nursing or therapy services as long as the PCS worker is performing duties that do not require one-on-one contact with the participant such as meal preparation and cleaning but should never be idle during the time they are billing for services. On rare occasions PT and OT can be performed concurrently when the provisions of services in this manner is determined to be more effective treatment. Otherwise, there should not be concurrent services provided to the participant.

**Participant Name:** ____________________________  **CPOC Begin Date:** ________  **End Date:** ________

Issued May 30, 2003
Revised August 7, 2008
This Medicaid Number does not match the medicaid number on the most recent PA (90705456079477).

Parish: 24 IBERVILLE
Region: 02
Date of Birth: 01/01/2010
Age: 9 Child
Case Open: 02/03/2015
Sex: 2 Female
Race: 1 White
Legal Status: 2 Minor
Is able to direct his/her own care: 
ID: not ID
Adaptive Functioning: Moderate
Residential Placement: 11 OCS Foster Care
Number of ID/DD/Special Needs in Home (excluding recipient): 0
Names: 
Current Education/Employment: 06 Special Education Only
Non-Chisolm reason: 
ICD10 Diagnosis: F88. OTHER DISORDERS OF PSYCHOLOGICAL I
**LSCIS CPOC Section 2 – Medical/Social/Family History**

<table>
<thead>
<tr>
<th>Support Coordinator</th>
<th>Submit for review by LDH</th>
<th>CPOC Type</th>
<th>Submit Date</th>
<th>Approval Status</th>
<th>Reviewer</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Q.R. Date</th>
<th>Edit</th>
<th>Void</th>
<th>Print</th>
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</thead>
<tbody>
<tr>
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<td>02/10/2013</td>
<td>02/09/2019</td>
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**PAST: Pertinent Historical Information**

**PRESENT: Describe Current Living Situation and Natural Supports:**

**HEALTH STATUS**

- **Physician:**
- **Immunization Current:**
- **Medical Diagnoses and Concerns/Significant Medical History (Include findings of last physical):**

**Psychiatric/Behavioral Concerns:**

**Dates of Evaluations/Documentation used to develop this CPOC**

- Social Evaluation
- Psychological Evaluation
- Psychiatric Evaluation
- Special Education Eval.
- Current IEP
- Behavior Management Plan
- Home Health Plan of Care
- Form 96 or Medical Records
- Pediatric Day Health POC
- SOA

**Expiration:**

**Permanent:**

**Describe:**
### Service Needs and Supports

<table>
<thead>
<tr>
<th>Service Needs/Description</th>
<th>How was Need Determined</th>
<th>Requested by Participant/Family</th>
<th>If Not Why Not?</th>
<th>Primary Goal</th>
<th>Receiving Medicaid</th>
<th>School</th>
<th>Community</th>
<th>Family</th>
<th>OCDD</th>
<th>Requires PA tracked by SC</th>
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<td>✅</td>
<td>✈</td>
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<td>✈</td>
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</tr>
<tr>
<td>Other (6) Gastro</td>
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<td></td>
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<td>✈</td>
<td>✈</td>
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<tr>
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<td>Other (4) Allergies</td>
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<td>✈</td>
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<td>FSA: Samsung tablet</td>
<td>Family</td>
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<td>Family does not want</td>
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<td></td>
</tr>
<tr>
<td>Diapers (1)</td>
<td>Incontinence Supplies</td>
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<td>Best possible health</td>
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<td>✈</td>
<td>✈</td>
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<tr>
<td>Other (1) Development Specialist</td>
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<td>Speech Therapy (1)</td>
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<td>Other (9) venue Example to Void</td>
<td>Family</td>
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</tr>
</tbody>
</table>
LSCIS CPOC Section 4 – Additional Information / CPOC Participants

<table>
<thead>
<tr>
<th>Planning Participants</th>
<th>Title and Agency Name</th>
<th>Additional Information about Service Needs and Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies received at school through the IEP. If no why not:

Support Coordinator has reviewed Medicaid Services Chart with the participant and family: If no why not:

Support Coordinator has provided the participant and family with information on Medicaid EPSDT Services: If no why not:

Support Coordinator has provided the participant and family with information on EPSDT Screening Services: If not why not:

EPSDT Screening Services requested: If yes referral Date: / / 

Participant Signature Date: / / 

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant’s need and that the services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child’s 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

Signature of Support Coordinator: / / 

S.C. Signature Date: / / 

Ready for Supervisor Review: 

Edit
LSCIS CPOC Section 5 – CPOC Approval Information

<table>
<thead>
<tr>
<th>CPOC History</th>
<th>CPOC Type</th>
<th>Support Coordinator</th>
<th>Submit for review by LDH</th>
<th>Submit Date</th>
<th>Approval Status</th>
<th>Reviewer</th>
<th>Begin Date</th>
<th>End Date</th>
<th>O.R. Date</th>
<th>Edit</th>
<th>Void</th>
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<tbody>
<tr>
<td>Interim</td>
<td>MAH</td>
<td>Marcia Hardy</td>
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</table>

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

Signature Support Coordinator Supervisor: ____________________________ Date: __/__/___

Submit for review by LDH: [ ]

Approval/Denial Information

By: ____________________________ Approval/Denial Date: __/__/___

Approval/Denial Notes: ____________________________
## LSCIS CPOC Quarterly Review

<table>
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<tr>
<th>Service Needs</th>
<th>Receiving/Exclusion of Services</th>
<th>Date of PA</th>
<th>Receiving amount PA</th>
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<tr>
<td>Dental Services (1)</td>
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<td>NA</td>
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<tr>
<td>Diapers (1)</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Incontinence Supplies</td>
<td>Yes</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>OT (1) Gastro</td>
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<tr>
<td>Allergies</td>
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<tr>
<td>Other (6) Development Specialist</td>
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<td>Other (3) FSA: Samsung tablet</td>
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<tr>
<td>Speech Therapy (1) Communication</td>
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</table>

**Health Changes**
- (Include Nutritional Changes)
- Safety Issues
- Changes in Living Situations
- Medicaid Services Chart
- Rights and Responsibilities
- Grievance Policy
- Abuse Policy
- Health Standards Provider complaint (1-800-660-3408)
- Medical Managed Care Program Assistance/Compliance Line (1-888-342-8207)

**Participant Questions**
- Are you receiving the services that you requested?
- Are the Services at the day/time needed?
- Are you pleased with the services that you are receiving?
- Are there Additional services that you need?

**Participant Comments**

**Support Coordinator:**

<table>
<thead>
<tr>
<th>Names of Attendees</th>
<th>Relation/Title/Agency</th>
<th>Date</th>
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LSCIS Prior Authorization Tracking Log
# LSCIS Prior Authorization Tracking Log for Medicaid Managed Care Program Services

## Medicaid Managed Care Program

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<tr>
<th>Support Coordinator</th>
<th>Type of Service Requested</th>
<th>Date of COP</th>
<th>Provider</th>
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<table>
<thead>
<tr>
<th>Date of Review by Provider/MMCCM:</th>
<th>Date of Referral to Provider/MMCCM:</th>
<th>Date of 2nd Referral to Provider/MMCCM:</th>
<th>Date of 15 Day Provider/MMCCM Contact Date:</th>
<th>Date of 35 Day Provider/MMCCM Contact Date:</th>
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<table>
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<tr>
<th>Date Packet Submitted to OXC/MCO:</th>
<th>Date Provider PA Request Packet Received:</th>
<th>Not Received:</th>
<th>Date of Referral to PAL (Untimely PA Packet Submission):</th>
<th>Date of Decision:</th>
<th>Date PA Notice Received:</th>
<th>Date of Referral to PAL (Untimely PA Notice):</th>
<th>Amount of Service Approved:</th>
<th>Date Renewal Sent and New Tracking Started:</th>
<th>Date Denial of Service Notice Received:</th>
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<table>
<thead>
<tr>
<th>Approval/Denial Status:</th>
<th>Reason for Denial:</th>
<th>Date MCO Appeal Rights Explained:</th>
<th>Offered to help with MCO Appeal Date:</th>
<th>Is Client Appealing:</th>
<th>Request Assistance with MCO Appeal:</th>
<th>Date Appeal Sent to MCO</th>
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<tr>
<th>20 Day MCO Appeal Follow Up:</th>
<th>Date of MCO Appeal Decision:</th>
<th>MCO Appeal Outcome:</th>
<th>MCO Appeal Notes:</th>
<th>Date Appeal Rights Explained:</th>
<th>Offered to help with appeal Date:</th>
<th>Is Client Appealing:</th>
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<th>20 Day Appeal Follow Up:</th>
<th>Date of Appeal Decision:</th>
<th>Appeal Outcome:</th>
<th>Date Appeal Notes:</th>
<th>Date MCO Appeal Notes:</th>
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## Notes:

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- 

[Save] [Cancel]
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<td>Case No.</td>
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<td>P/P Contact</td>
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<td>Service Participants</td>
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<td>End Mileage</td>
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<tr>
<td>Service Need</td>
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<tr>
<td>Notes</td>
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</tbody>
</table>
# Early Periodic Screening Diagnosis and Training (EPSDT) – Targeted Population Support Coordination

**Description**

EPSDT targeted support coordination is a Medicaid State Plan Service. Support Coordination is a service that can assist families to access the services available to them through Medicaid EPSDT. This includes all services that individuals under age 21 may be entitled to receive with a Medicaid Card. These services may help address the individual’s medical, social and educational needs. The Support Coordinator will review all available services and assist with making referrals for the services they may be eligible to receive. These **MAY** include services such as medical equipment, occupational, physical or speech therapy, Personal Care Service (PCS), Home Health and EPSDT screening. Support Coordinators will assure families will also be informed of any new services in the future that may help their children.

**EPSDT services are not waiver services.**

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age → 3 to 21 years old</td>
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</tr>
</tbody>
</table>

- **Individuals are on the DD Request for Services Registry**
  - Placement on the DD Request for Services Registry on or after October 20, 1997 and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of October 20, 1997 or the date they were placed on the RFSR; **OR**
  - Placement on the DD Request for Services Registry (RFSR) on or after October 20, 1997 but who did not have a D & E by the later of October 20, 1997 or the date they were placed on the DD RFSR. Those in this group who subsequently pass or passed the D & E process are eligible for these targeted support coordination services. For those who do not pass the D & E process or who are not undergoing a D & E, they may still receive support coordination services if they meet the definition of a person with special needs.
  - Must have documentation from Medicaid to substantiate that the EPSDT recipient meets the definition of special needs for support coordination services (e.g., receipt of special education services through state or local education agency, receipt of regular services from one or more physicians, receipt of or application for financial assistance such as SSI because of medical condition or the unemployment of the parent due to the need to provide specialized care for the child, a report by the participants physician of multiple health or family issues that impact the participants ongoing care or a determination of developmental delay based upon the Parent’s Evaluation of Pediatric Status, the Brignance Screens, the Child Development Inventories, Denver Developmental Assessment, or any other nationally recognized diagnostic tool. **AND**
  - **Under the age of 21, AND**
  - **Are Medicaid Eligible**

**Follow-up & Monitoring**

The Support Coordinator will follow-up with the participant at least monthly regarding all approved services, to ensure they are receiving services in the amount approved and at the times requested. (If the participant is not satisfied, the support coordinator will follow-up with the provider.) The support coordinator will meet face-to-face with the participant & family at least one time per quarter. The Health Standards Office will conduct Complaint investigations for all Support Coordination Agencies. They will also conduct monitoring for RFP Contracted Support Coordination Agencies utilizing a 5% sample annually.

**Requests for EPSDT Targeted Population Support Coordination should be directed to the BHSF/SRI toll-free Help Line at 1-800-364-7828**

## Legacy Medicaid
### Referral to Provider
#### EPSDT - Targeted Population

| Date:    |  |
|----------|  |

**TO:** Provider Name

**FROM:** Support Coordination Agency

<table>
<thead>
<tr>
<th>Support Coordinator’s Name:</th>
<th>Support Coordinator’s Phone #:</th>
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**Provider #:**

<table>
<thead>
<tr>
<th>City:</th>
<th>State/Zip:</th>
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</table>

**Address:**

<table>
<thead>
<tr>
<th>Provider #:</th>
<th>Support Coordinator’s Name:</th>
<th>Support Coordinator’s Phone #:</th>
</tr>
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<tbody>
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</table>

**RE:** Service Type (if DME be specific):

<table>
<thead>
<tr>
<th>Service Name:</th>
<th>Amount/# of Hours of Service:</th>
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<tbody>
<tr>
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<thead>
<tr>
<th>Initial</th>
<th>Renewal</th>
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</table>

**Participant Name:**

<table>
<thead>
<tr>
<th>MID#:</th>
<th>Phone#:</th>
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**Address:**

<table>
<thead>
<tr>
<th>Participant Name:</th>
<th>MID#:</th>
<th>Phone#:</th>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State/Zip:</th>
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This is to inform you that this individual is receiving EPSDT - Targeted Population Support Coordination Services and we are sending this notice to: (Check the following that apply)

1. Make a referral for the above noted service. Please make sure that you include our Provider #, Agency Name and Address on the request for Prior Authorization (PA) to Medicaid. We are also requesting that you send us a copy of the PA request packet at the same time that it is sent to Medicaid/Molina.

2. The participant has asked that their schedule for your services be changed as per the attached Typical Weekly Schedule form. If this presents a scheduling problem, please contact the Support Coordinator so that we can all discuss this with the participant/family.

3. This is a reminder that the above named participant’s PA for your service expires on ___/___/___ and the renewal needs to be sent to Molina/Medicaid for continued services.

4. The Medicaid PAL (Prior Authorization Liaison) has informed us they need the following additional information in order to process the request for the PA packet you submitted:

5. Other:

---

Support Coordinator’s Signature  
Issued May 30, 2003  
BHSF-PF-03-016  
Reissued August 4, 2006  
Revised October 29, 2010  
Revised March 26, 2015
# STATE OF LOUISIANA
Louisiana Department of Health
Bureau of Health Services Financing
REQUEST FOR PRIOR AUTHORIZATION  PA Number

Molina Medicaid Solutions
FAX TO: (225) 216-6481  CONTINUATION OF SERVICES _____YES _____ NO

## 14 – EPSDT PERSONAL CARE SERVICES

<table>
<thead>
<tr>
<th>(1) PRIOR AUTHORIZATION TYPE:</th>
<th>(2) RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER</th>
<th>(3) SOCIAL SECURITY #</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT PERSONAL CARE SERVICES</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>(4) RECIPIENT LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
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<tr>
<td></td>
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<table>
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<tr>
<th>(5) DATE OF BIRTH</th>
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</table>

<table>
<thead>
<tr>
<th>(6) MEDICAID PROVIDER NUMBER (7-DIGIT)</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>(7) SERVICE TREATMENT PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEGIN DATE (MMDDYYYY)</td>
</tr>
<tr>
<td>END DATE (MMDDYYYY)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(8) IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES       NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(9) DIAGNOSIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CODE &amp; DESCRIPTION</td>
</tr>
<tr>
<td>SECONDARY CODE &amp; DESCRIPTION</td>
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</table>

<table>
<thead>
<tr>
<th>(10) PRESCRIPTION DATE (MMDDYYYY)</th>
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<table>
<thead>
<tr>
<th>(10A) STATUS CODES:</th>
</tr>
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<tbody>
<tr>
<td>2 = APPROVED</td>
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<tr>
<td>3 = DENIED</td>
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<table>
<thead>
<tr>
<th>(11) PRESCRIBING PHYSICIAN’S NAME AND/OR NUMBER:</th>
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</table>

## DESCRIPTION OF SERVICES FOR INTERNAL USE ONLY

<table>
<thead>
<tr>
<th>(12) PROCEDURE CODE</th>
<th>(12A) MODIFIER</th>
<th>(12B) DESCRIPTION OF SERVICES EACH 15 MINUTES</th>
<th>(12C) REQUESTED UNITS</th>
<th>AUTHORIZED UNITS</th>
<th>STATUS</th>
<th>P.A. MESSAGE/DENIAL CODE (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1019</td>
<td>EP</td>
<td>EPSDT-Personal Care Service, each 15 minutes</td>
<td></td>
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<table>
<thead>
<tr>
<th>(13) PROVIDER NAME:</th>
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<table>
<thead>
<tr>
<th>ADDRESS:</th>
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<table>
<thead>
<tr>
<th>CITY:</th>
<th>STATE:</th>
<th>ZIPCODE</th>
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<table>
<thead>
<tr>
<th>TELEPHONE: (_____) _____ ______</th>
<th>FAX NUMBER: (_____) _____ ______</th>
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<table>
<thead>
<tr>
<th>(14) COMMENTS:</th>
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<table>
<thead>
<tr>
<th>(15) PROVIDER SIGNATURE:</th>
<th>DATE OF REQUEST:</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>
Instructions For Completing Prior Authorization Form (PA-14)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA MEDICAID SOLUTIONS.

FIELD NO. 2 ENTER RECIPIENT'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.

FIELD NO. 3 ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER.

FIELD NO. 4 ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THE RECIPIENT'S MEDICAID CARD.

FIELD NO. 5 ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 6 ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER.

FIELD NO. 7 ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).

FIELD NO. 8 PLACE A CHECK MARK IN THE ‘YES’ OR ‘NO’ BOX TO INDICATE WHETHER OR NOT THE RECIPIENT IS CURRENTLY RECEIVING SERVICES.

FIELD NO. 9 ENTER THE NUMERIC ICD-10 -DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.

FIELD NO. 10 ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)

FIELD NO. 11 ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES.

FIELD NO. 12 ENTER THE HCPCS CODE.

FIELD NO. 12A ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE).

FIELD NO. 12B ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED.

FIELD NO. 12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN. CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (1 UNIT = 15 MINUTES) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS COVERED IN THE TREATMENT PLAN. THIS WILL GIVE THE TOTAL UNITS REQUESTED. BELOW ARE TWO EXAMPLES ON THE PROPER WAY TO CALCULATE THE TOTAL UNITS REQUESTED:

EXAMPLE 1) REQUESTING FOUR-HOURS PER DAY FOR A SIX MONTH PERIOD:

4 HOURS PER DAY = 16 UNITS PER DAY, 7 DAYS A WEEK, 26 WEEKS =
16 X 7 X 26 = 2912 TOTAL UNITS REQUESTED

EXAMPLE 2) REQUESTING TWO-HOURS PER DAY ON WEEKENDS AND FOUR-HOURS PER DAY ON WEEKDAYS:

2 HOURS PER DAY (WEEKENDS) = 8 UNITS PER DAY, 2 DAYS A WEEK, 26 WEEKS =
8 X 2 X 26 = 416 TOTAL UNITS REQUESTED FOR WEEKENDS

4 HRS. PER DAY (WEEKDAYS) = 16 UNITS PER DAY, 5 DAYS A WEEK, 26 WEEKS =
16 X 5 X 26 = 2080 TOTAL UNITS REQUESTED FOR WEEKDAYS

THE TOTAL UNITS REQUESTED WOULD BE THE COMBINATION OF THE TOTAL WEEKEND UNITS (416) AND WEEKDAY UNITS (2080), WHICH WOULD EQUAL TO 2496 TOTAL UNITS REQUESTED. THIS IS THE NUMBER (2496) TO ENTER IN FIELD NUMBER 12C.

FIELD NO. 13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE.

FIELD NO. 14 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

FIELD NO. 15 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA MEDICAID SOLUTIONS.

PRIOR AUTHORIZATION PCS DEPARTMENT TOLL-FREE NO. IS: 1-800-807-1320, then press Option 1

PRIOR AUTHORIZATION FAX NO. IS: 1-225-216-6481
REQUEST FOR MEDICAID EPSDT - PERSONAL CARE SERVICES
(Personal Care Services are to be provided in the home and not in an institution)

I. IDENTIFYING INFORMATION

| Applicant Name: |
| MiD# |
| Address: | Ph # |
| | ( ) |
| | □ Male □ Female |

| DOB: |

| 2. Responsible Party/Curator: |
| Relationship: |
| Address: | Home Phone # |
| | ( ) |

| Work or Cell Phone # |
| ( ) |

By signing this form I give my consent for my medical information to be released to the Department of Health and Hospitals to be used in determining eligibility for Personal Care Services.

Signature: ___________________________ Date: ___________________________

II. MEDICAL INFORMATION

NOTE: The following information is to be completed by the applicant’s attending physician.

1. Patient Name:

2. Primary Diagnosis:  Diagnosis Code:

| Secondary Diagnosis: | Diagnosis Code: |

3. Physical Examination:

| General | Head and CNS |
| Mouth and EENT | Chest |
| Heart and Circulation | Abdomen |
| Genitalia | Extremities |

| Skin | Height |
| Wt. | Pulse |
| Resp | Temp |
| B/P | Bowel/Bladder Control |

Impaired Vision

| □Glasses | □Hearing Aid |

Lab Results:

| HCT | HCB |
| U/A | Radiology |

4. Special Care/Procedures: check appropriate box and give type, frequency, size, stage and site when appropriate

| Trach Care: | Daily | PRN |
| Respiratory: | Ventilator | Daily | Other |
| Suctioning/Oral Care: | Daily | PRN |
| Glucose Monitoring: | Insulin Injections | Daily | Other |
| Restraints (positioning): |
| Dialysis |
| Urinary Catheter |
| Seizure Precautions |
| Ostomy |
| IV |
| Decubitus/Stage |
| Diet/Tube Feeding |
| Rehab (OT,PT,ST) |

Assistive Device:

| □Walker | □Cane |
| □Bed/Chair | □Lift |
| □Other |

5. Medications

<table>
<thead>
<tr>
<th>Dosage</th>
<th>Frequency</th>
<th>Route</th>
</tr>
</thead>
</table>

|        |           |       |
|        |           |       |
|        |           |       |
|        |           |       |

EPSDT-PCS Form 90
Revised 11/01/10
II. MEDICAL INFORMATION (Continued)

6. Recent Hospitalizations: (include psychiatric):

7. Mental Status/Behavior: Check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oriented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive</td>
<td></td>
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<tr>
<td>Verbal</td>
<td></td>
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<tr>
<td>Forgetful</td>
<td></td>
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<tr>
<td>Non-responsive</td>
<td></td>
<td></td>
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<tr>
<td>Depressed</td>
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<tr>
<td>Physically Abusive</td>
<td></td>
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<tr>
<td>Comatose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
<td></td>
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<tr>
<td>Injures</td>
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</tbody>
</table>

8. Impairments: Please rate the following. 1= Mild, 2= Moderate, 3= Severe

<table>
<thead>
<tr>
<th></th>
<th>(1 2 3)</th>
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</thead>
<tbody>
<tr>
<td>Walking</td>
<td></td>
</tr>
<tr>
<td>Spasticity</td>
<td></td>
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<tr>
<td>Limb weakness</td>
<td></td>
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<tr>
<td>Hypotonia</td>
<td></td>
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<tr>
<td>Chronic Resp distress</td>
<td></td>
</tr>
<tr>
<td>Chronic heart failure</td>
<td></td>
</tr>
<tr>
<td>Speech impairment</td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
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<tr>
<td>Developmental delay</td>
<td></td>
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<tr>
<td>Hearing impairment</td>
<td></td>
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<tr>
<td>Vision impairment</td>
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<tr>
<td>Oral feeding</td>
<td></td>
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<tr>
<td>Bladder and bowel incontinence</td>
<td></td>
</tr>
<tr>
<td>Intellectual impairment</td>
<td></td>
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</tbody>
</table>

III. LEVEL OF CARE DETERMINATION

Activities of Daily Living:

Based on the recipient’s impairment, the attending physician should check the appropriate box as it applies to the recipient’s ability to perform this age appropriate tasks using the following definitions and PCS Level of Assistance Guide:

Not Independent at this Age – not age appropriate to perform this task independently

Independent – recipient able to perform task without assistance

Limited Assistance – recipient aids in task, but receives help from other persons some of the time

Extensive Assistance – recipient aids in task, but receives help from other persons all of the time

Maximal Assistance – recipient is entirely dependent on other persons

Note: An additional 15 minutes can be added to bathing, dressing and toileting if mobility/transfer assistance is required

(EPSDT – PCS Level of Assistance Guide)

This is a general guide to assist physicians with determining the level of assistance recipients require to complete their activities of daily living (ADL). Additional time to complete the tasks will be considered if there is sufficient medical documentation provided. Please use the comments section below and attach documentation to support the need for additional time to complete the ADL’s. In addition to the PCS tasks listed, assistance with incidental household chores may be approved. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the recipient.
III. LEVEL OF CARE DETERMINATION (Continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not Independent at this Age</th>
<th>Independent</th>
<th>Limited Assistance</th>
<th>Extensive Assistance</th>
<th>Maximal Assistance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
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<tr>
<td>Grooming</td>
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<tr>
<td>Toileting</td>
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<tr>
<td>Eating</td>
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NOTE: The following information is to be completed by the applicant’s attending physician. Check the appropriate box using the definitions and EPSDT PCS Level of Assistance Guide to assist with determining the level of care.

Level of care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. **Please select one of the following:**

This individual’s condition includes a need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization. May include professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

- [ ] Yes, this individual requires this level of care.
- [ ] No, this individual does not require this level of care.

**Mobility/Transfer Requirements:** Please indicate below the activities of daily living for which the recipient will require assistance with mobility/transfer.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
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</tbody>
</table>

**Medical Appointments:**

Will the recipient need the PCS worker to accompany him/her to medical appointments? [ ] Yes [ ] No

How often will the recipient have scheduled medical appointments? [ ] weekly [ ] monthly [ ] quarterly [ ] other ________

Reason for PCS worker to accompany child to medical appointments: __________________________________________

IV. PHYSICIAN’S ORDER

The above named patient is in need of EPSDT PCS due to his/her current medical condition. I am prescribing Personal Care Services for ____________ hours, ____________ days a week as determined by the level of care determination.

<table>
<thead>
<tr>
<th>Physician’s Name (type or print):</th>
<th>Phone: (       )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

I certify/recertify that I am the attending physician for this patient and that the information provided is accurate and correct to the best of my knowledge. I authorize these EPSDT personal care services and will periodically review the plan. In my professional opinion, the services listed on this form are medically necessary and appropriate due to the child’s medical condition. I understand that if I knowingly authorize services that are not medically necessary, I may be in violation of Medicaid rules and subject to sanctions described therein. I understand a face to face evaluation must be held between recipient and physician.

Physician’s Signature __________________________ Date ________________
Molina Medicaid Solutions
FAX TO: (225) 216-6481
CONTINUATION OF SERVICES _____YES _____ NO

<table>
<thead>
<tr>
<th>PRIOR AUTHORIZATION TYPE: (1)</th>
<th>RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)</th>
<th>Social Security No. (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>06 - Home Health Services</td>
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</tr>
<tr>
<td></td>
<td>RECIPIENT LAST NAME FIRST MI DATE OF BIRTH (4)</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICAID PROVIDER NUMBER (7-DIGIT) (6)</td>
<td>SERVICE TREATMENT PLAN (7)</td>
<td>IS RECIPIENT CURRENTLY RECEIVING THESE SERVICES (8)</td>
</tr>
<tr>
<td></td>
<td>BEGIN DATE (MMDDYYYY)</td>
<td>END DATE (MMDDYYYY)</td>
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<tr>
<td>DIAGNOSIS : PRIMARY CODE &amp; DESCRIPTION</td>
<td>PRESCRIPTION DATE (10) (MMDDYYYY)</td>
<td>STATUS CODES: 2 = APPROVED 3 = DENIED</td>
</tr>
<tr>
<td></td>
<td>PRESCRIBING PHYSICIAN'S NAME AND/OR NUMBER: (11)</td>
<td></td>
</tr>
<tr>
<td>SECONDARY CODE &amp; DESCRIPTION</td>
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</tr>
</tbody>
</table>

**DESCRIPTION OF SERVICES**

<table>
<thead>
<tr>
<th>PROCEDURE CODE (12)</th>
<th>MODIFIERS (12A)</th>
<th>DESCRIPTION (12B)</th>
<th>REQUESTED UNITS (12C)</th>
<th>AUTHORIZED UNITS</th>
<th>AMOUNT</th>
<th>AMOUNT</th>
<th>STATUS</th>
<th>P.A. MESSAGE/DENIAL CODE (S)</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

(13) (14) CASE MANAGER INFORMATION:

PROVIDER NAME: ___________________________ NAME: ___________________________
ADDRESS: ________________________________________________________________
ADDRESS: ________________________________________________________________
CITY: ___________________________ STATE: ________ ZIPCODE ____________
CITY: ___________________________ STATE: ________ ZIPCODE ____________
TELEPHONE: (___) _______ FAX NUMBER: (___) _______ TELEPHONE (___) _______ FAX NUMBER: (___) _______

(15) PROVIDER SIGNATURE: ___________________________ DATE OF REQUEST: ___________________________

PA-07 FORM
Revised 5/11/2018
Instructions For Completing Prior Authorization Form (PA-07)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

FIELD NO. 2  ENTER RECIPIENT’S 13 DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER
FIELD NO. 3  ENTER THE RECIPIENT’S SOCIAL SECURITY NUMBER
FIELD NO. 4  ENTER THE RECIPIENT’S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON RECIPIENT’S MEDICAID CARD
FIELD NO. 5  ENTER THE RECIPIENT’S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)
FIELD NO. 6  ENTER THE PROVIDER’S 7-DIGIT MEDICAID NUMBER
FIELD NO. 7  ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)
FIELD NO. 8  PLACE A CHECK MARK IN THE ‘YES’ OR ‘NO’ BOX TO INDICATE WHETHER OR NOT THE RECIPIENT IS CURRENTLY RECEIVING SERVICES
FIELD NO. 9  ENTER THE NUMERIC ICD 10-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION
FIELD NO.10 ENTER THE DAY THE PRESCRIPTION, DOCTOR’S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY YYYY=YEAR)
FIELD NO.11 ENTER THE NAME OF THE RECIPIENT’S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES
FIELD NO.12 ENTER HCPCS CODE
FIELD NO.12A ENTER THE CORRESPONDING MODIFIER (S) WHEN APPROPRIATE.
FIELD NO.12B ENTER THE HCPCS CODE’S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED
FIELD NO.12C ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN, CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS REQUESTED ( TAKEN FROM THE SERVICES TREATMENT DATES (FIELD NO. 7 ABOVE). THIS WILL GIVE THE TOTAL UNITS REQUESTED.
FIELD NO.13 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE
FIELD NO 14 ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE RECIPIENT’S CASE MANAGER, IF AVAILABLE.
FIELD NO.15 PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.
FIELD NO.16 DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF THIS FIELD IS NOT DATED

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA.

HOME HEALTH TOLL-FREE NO. IS 1-800-807-1320, then press Option 1
HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225-216-6481
### HOME HEALTH CERTIFICATION AND PLAN OF CARE

#### 1. Patient’s HI Claim No.

#### 2. Start Of Care Date

#### 3. Certification Period

- **From:**
- **To:**

#### 4. Medical Record No.

#### 5. Provider No.

#### 6. Patient’s Name and Address

#### 7. Provider’s Name, Address and Telephone Number

#### 8. Date of Birth

#### 9. Sex
- **M**
- **F**

#### 10. Medications: Dose/Frequency/Route (N)eW (C)hanged

#### 11. ICD
- **Principal Diagnosis**
  - Date

#### 12. ICD
- **Surgical Procedure**
  - Date

#### 13. ICD
- **Other Pertinent Diagnoses**
  - Date

#### 14. DME and Supplies

#### 15. Safety Measures


#### 17. Allergies

<table>
<thead>
<tr>
<th>A. Functional Limitations</th>
<th>B. Activities Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amputation</td>
<td>6. Partial Weight Bearing</td>
</tr>
<tr>
<td>2. Bowel/Bladder (Incontinence)</td>
<td>7. Independent At Home</td>
</tr>
<tr>
<td>3. Contracture</td>
<td>8. Crutches</td>
</tr>
<tr>
<td>4. Hearing</td>
<td>9. Cane</td>
</tr>
<tr>
<td>5. Paralysis</td>
<td>A. Wheelchair</td>
</tr>
<tr>
<td>9. Legally Blind</td>
<td>2. Bedrest BRP</td>
</tr>
<tr>
<td>A. Dyspnea With Minimal Exertion</td>
<td>7. Independent At Home</td>
</tr>
<tr>
<td>B. Other (Specify)</td>
<td>3. Up As Tolerated</td>
</tr>
<tr>
<td>1. Oriented</td>
<td>4. Transfer Bed/Chair</td>
</tr>
<tr>
<td>3. Forgetful</td>
<td>5. Exercise Prescribed</td>
</tr>
<tr>
<td>4. Somnolence</td>
<td>5. exercises Prescribed</td>
</tr>
<tr>
<td>6. Depressed</td>
<td>7. Agitated</td>
</tr>
<tr>
<td>8. Lethargic</td>
<td>8. Other</td>
</tr>
<tr>
<td>10. Exercise Prescribed</td>
<td>11. Other (Specify)</td>
</tr>
</tbody>
</table>

#### 18. Mental Status

<table>
<thead>
<tr>
<th>1. Oriented</th>
<th>3. Forgetful</th>
<th>5. Disoriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oriented</td>
<td>2. Forgetful</td>
<td>3. Disoriented</td>
</tr>
</tbody>
</table>

#### 19. Prognosis

<table>
<thead>
<tr>
<th>1. Poor</th>
<th>2. Guarded</th>
<th>3. Fair</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Good</td>
<td>5. Excellent</td>
<td></td>
</tr>
</tbody>
</table>

#### 20. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

#### 21. Goals/Rehabilitation Potential/Discharge Plans

#### 22. Goals/Rehabilitation Potential/Discharge Plans

#### 23. Nurse’s Signature and Date of Verbal SOC Where Applicable:

#### 24. Physician’s Name and Address

#### 25. Date of HHA Received Signed POT

#### 26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

#### 27. Attending Physician’s Signature and Date Signed

#### 28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.
Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861 and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to: Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ___________________________ Date of birth: __________ Age: __________</td>
</tr>
<tr>
<td>Medicaid ID: __________ Height: __________ Weight __________</td>
</tr>
<tr>
<td>Recipient's Address __________________________________________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescribing Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber's Name: ______________________________________________  Phone #: ___________________</td>
</tr>
<tr>
<td>Address: _______________________________________________________ Fax # ______________________</td>
</tr>
</tbody>
</table>

› **Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD CM code):**
  - Primary: __________________________
  - Secondary: __________________________

› **Specify Urine/Fecal incontinence diagnoses (Specify ICD CM code):**
  - Primary: __________________________
  - Secondary: __________________________

› **Mobility**
  - ☐ Ambulatory
  - ☐ Minimal assistance ambulating
  - ☐ Transfer Assistance
  - ☐ Confined to bed or chair

› **Extraordinary Needs - if you are requesting more than 8 per day ONLY**
  Complete and provide additional supporting documentation for acute medical condition and/or extenuating circumstances for the increased need for incontinence products

› **Mental Status/Level of Orientation**
  - ☐ Has the ability to communicate needs
  - ☐ Sometimes communicates needs
  - ☐ Unable to communicate needs

› **Frequency of anticipated change**
  - During Day time (6 AM-10PM) ________.
  - During Night time (10PM – 6 AM) ________.

› **Additional supporting Diagnoses**
  - □ Home Health
  - □ Skilled Nursing Services
  - □ Personal Care Services
  - □ Other __________________________

› **List any medications and/or nutritional therapy that would increase urine or fecal output:**

| Specify incontinence supply, size, quantity/24 hours and duration of need: |
|-----------------------------|---------------------|---------------------|
| Diapers (Check one):        | Qty per day | Size (S, M, L, XL) |
| [ ] child size        | [ ] adult-sized |
| [ ] youth-sized       | [ ] adult-sized |
| Pull-ups (Check one):      | Qty per day | Size (S, M, L, XL) |
| [ ] child size        | [ ] adult-sized |
| [ ] youth-sized       | [ ] adult-sized |
| Liner/shield (Check one):  | Qty per day | Size (S, M, L, XL) |
| [ ] child size        | [ ] adult-sized |
| [ ] youth-sized       | [ ] adult-sized |

By my signature I attest that I have seen the patient and the item prescribed is medically necessary. I have personally completed this request and a copy will be maintained in the patient’s medical record.

Prescriber’s Signature: __________________________________________

Date: __________________________

› **Comments**

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

☐ Additional documentation attached
Disposable Incontinence Products (T4521 - T4535 & T4539)

Standards of Coverage:

**Diapers** are covered for individual’s age four years through age twenty years when:
- Specifically prescribed by the recipient’s physician, and
- The individual has a medical condition resulting in permanent bowel/bladder incontinence, and
- The individual would not benefit from or has failed a bowel/bladder training program when appropriate for the medical condition.

**Pull-on briefs** are covered for individual’s age four years through age twenty years when:
- Specifically prescribed by the recipient’s physician, and
- There is presence of a medical condition resulting in permanent bowel/bladder incontinence, and
- The recipient has the cognitive and physical ability to assist in his/her toileting needs.

**Liners/guards** are covered for individual’s age four years through age twenty years when:
- Specifically prescribed by the recipient’s physician, and
- They cost-effectively reduce the amount of other incontinence supplies needed.

*Note: Permanent loss of bladder and/or bowel control is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration.*

**Documentation:** The prescription request form for disposable incontinence products may be completed by the physician, or a physician’s prescription along with the required documentation as listed below.

**Documentation** must reflect the individual’s current condition and include the following:
- Diagnosis (specific ICD-9-CM code) of condition causing incontinence (primary and secondary diagnosis).
- Item to be dispensed.
- Duration of need (*physician must provide*).
- Size
- Quantity of item and anticipated frequency the item requires replacement.
- Description of mobility/limitations
To avoid unnecessary delays and need for reconsideration, care should be taken to use the correct HCPC code from among T4521-T4535 & T4539.

Documentation for extraordinary needs must include all of the above and:
- Description of mental status/level of orientation
- Indicate current supportive services
- Additional supporting diagnosis to justify increased need for supplies
- Additional documentation to justify increased need may include but are not limited to any prescriptions that would increase urinary or fecal output.

If completed, DHH’s “Prescription Request Form for Disposable Incontinence Supplies” collects this information.

Approved providers of incontinence products:
- Pharmacy
- Home health agency
- Durable medical equipment provider

Prior Authorization Requirements: Prior authorization is required for all disposable incontinence supplies. The PA requests shall meet all previously defined criteria for:
- Eligible recipient.
- Eligible provider.
- Covered product.
- Documentation requirements - the prescription request form for disposable incontinence products may be completed, or a physician’s prescription along with the required documentation as indicated above.

Quantity Limitations:
- Disposable incontinence supplies are limited to eight per day.
- ICF-MR and nursing facility residents are excluded as these products are included in the facility per diem.
- Additional supporting documentation is required for requests that exceed the established limit.

Dispensing and Billing:
- Only a one-month supply may be dispensed at any time as initiated by the recipient.
- Bill one unit per item. Shipping costs are included in the DHH maximum allowable payment and may not be billed separately.
- Although specific brands are not required, DHH maximum allowable amounts may preclude the purchase of some products. The rate has been established so that the majority of products on the market are obtainable.
Providers should always request authorization for the appropriate product for the recipient’s current needs.

- Providers must provide at the minimum, a moderate absorbency product that will accommodate a majority of the Medicaid recipient’s incontinence needs. Supplying larger quantities of inferior products is not an acceptable practice.
- For recipients requesting a combination of incontinence supplies, the total quantity shall not exceed the established limit absent approval of extraordinary needs.
- Because payment cannot exceed the number of units prior authorized, providers who choose to have incontinent supplies shipped directly from the manufacture to the recipient’s home shall be responsible for any excess over the number of supplies approved by the prior authorization.
Appendix R-2

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P.O. BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 08/01/2006  RECIPIENT NAME
PRIOR AUTH. NBR  RECIPIENT NUMBER

PROVIDER NUMBER

DEAR PROVIDER,

THE RECIPIENT'S REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN
APPROVED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

-----------------------------
PROCEDURE: T4526       ADULT SIZE PULL-ON MED
REQUESTED: 917         APPROVED: 917
DATES OF SERVICE: 08/01/2006 - 12/31/2006  STATUS: APPROVED

PROCEDURE: T4526       ADULT SIZE PULL-ON MED
REQUESTED: 1           APPROVED: 1
DATES OF SERVICE: 08/01/2006 - 12/31/2006  STATUS: APPROVED
-----------------------------

THIS RECIPIENT HAS BEEN DEEMED AS A "CHRONIC NEEDS CASE". WRITE "CHRONIC NEEDS CASE" ON TOP OF THE NEXT PRIOR AUTHORIZATION REQUEST.

SUBMIT ONLY THE PRIOR AUTHORIZATION FORM AND THE DOCTOR'S STATEMENT STATING THE CONDITION OF THE PATIENT HAS NOT CHANGED.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:
OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA  70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/25/2009  RECIPIENT NAME
PRIOR AUTH. NBR  RECIPIENT NUMBER 8382978155180

AAA CARE LLC
P O BOX 640402
KENNER LA 70064

PROVIDER NUMBER 1461610
DEAR PROVIDER,

THE RECIPIENT’S REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN
PARTIALLY APPROVED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

PROCEDURE:  T1019 EP  PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED:  2012
APPROVED:  1456
DIFFERENCE:  1456
DATES OF SERVICE: 05/12/2009 - 11/12/2009 STATUS: PARTIALLY APPROVED

---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

YOU ASKED FOR 4 HOURS PER DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES. BASED ON THE MEDICAL AND SOCIAL INFORMATION PROVIDED, WE HAVE APPROVED FOR YOU TO BEGIN RECEIVING 2 HOURS A DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES.

PLEASE NOTE THAT ALL TIME ALLOTMENTS FOR ACTIVITIES OF DAILY LIVING ARE APPROVED AS REQUESTED EXCEPT FOR MEAL PREPARATION AND MEDICAL APPOINTMENTS.

35 MINUTES FOR BATHING
15 MINUTES FOR DRESSING
15 MINUTES FOR GROOMING
15 MINUTES FOR TOILETING
15 MINUTES FOR EATING

20 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES
WE DID NOT APPROVE TIME FOR MEAL PREPARATION AS THE INFORMATION INDICATES THAT YOUR MOTHER PREPARES REGULAR MEALS. PLEASE EXPLAIN THE NEED FOR PERSONAL CARE SERVICE WORKER TO PREPARE MEALS OR HELP THE MOTHER.

PLEASE PROVIDE INFORMATION AS TO THE NEED FOR THE PERSONAL CARE SERVICE WORKER TO ACCOMPANY RECIPIENT TO THE DOCTOR’S OFFICE.
THE HOURS NOT APPROVED WERE REFERRED TO THE PRIOR AUTHORIZATION LIAISON IN ORDER TO OBTAIN THE INFORMATION NEEDED TO MAKE A DETERMINATION AS TO WHETHER THE ADDITIONAL HOURS CAN BE APPROVED. WE ARE GOING TO REQUEST ADDITIONAL INFORMATION TO JUSTIFY THE HOURS OF SERVICE NOT APPROVED. YOU WILL RECEIVE A SEPARATE NOTICE APPROVING OR DENYING THESE HOURS.

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/25/2009 PROVIDER NAME AAA CARE LLC
PRIOR AUTH. NBR 91B550860 PROVIDER NUMBER 1461610

************************************************
* THIS IS NOT A BILL *
************************************************

RECIPIENT NUMBER
CCN NUMBER

DEAR

YOUR REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN
PARTIALLY APPROVED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

----------------------------------------
PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED: 2912
APPROVED: 1456
DIFFERENCE: 1456
DATES OF SERVICE: 05/12/2009 - 11/12/2009 STATUS: PARTIALLY APPROVED

----------------------------------------

YOU ASKED FOR 4 HOURS PER DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES. BASED
ON THE MEDICAL AND SOCIAL INFORMATION PROVIDED, WE HAVE APPROVED FOR YOU TO
BEGIN RECEIVING 2 HOURS A DAY, 7 DAYS A WEEK OF PERSONAL CARE SERVICES.

PLEASE NOTE THAT ALL TIME ALLOTMENTS FOR ACTIVITIES OF DAILY LIVING ARE
APPROVED AS REQUESTED EXCEPT FOR MEAL PREPARATION AND MEDICAL APPOINTMENTS.

35 MINUTES FOR BATHING
15 MINUTES FOR DRESSING
15 MINUTES FOR GROOMING
15 MINUTES FOR TOILETING
15 MINUTES FOR EATING

20 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES
WE DID NOT APPROVE TIME FOR MEAL PREPARATION AS THE INFORMATION INDICATES THAT
YOUR MOTHER PREPARES REGULAR MEALS. PLEASE EXPLAIN THE NEED FOR PERSONAL CARE
SERVICE WORKER TO PREPARE MEALS OR HELP THE MOTHER.

PLEASE PROVIDE INFORMATION AS TO THE NEED FOR THE PERSONAL CARE SERVICE WORKER
TO ACCOMPANY RECIPIENT TO THE DOCTOR'S OFFICE.

THE HOURS NOT APPROVED WERE REFERRED TO THE PRIOR AUTHORIZATION LIAISON IN
ORDER TO OBTAIN THE INFORMATION NEEDED TO MAKE A DETERMINATION AS TO WHETHER
THE ADDITIONAL HOURS CAN BE APPROVED. WE ARE GOING TO REQUEST ADDITIONAL
INFORMATION TO JUSTIFY THE HOURS OF SERVICE NOT APPROVED. YOU WILL RECEIVE A SEPARATE NOTICE APPROVING OR DENYING THESE HOURS.

THIS INFORMATION SHOULD BE PROVIDED BY YOUR PRIMARY CARE PHYSICIAN.

YOU MAY HAVE YOUR CASE MANAGER ASSIST YOU WITH OBTAINING MEDICAID SERVICES. IF YOU DO NOT HAVE A CASE MANAGER AND WOULD LIKE TO OBTAIN ONE, YOU SHOULD CALL STATISTICAL RESOURCES, INC (SRI) AT 1-800-364-7828.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 61030, BATON ROUGE, LOUISIANA 70821-8030

DATE 06/25/2009
PRIOR AUTH. NBR

RECIPIENT NAME
RECIPIENT NUMBER

SHARING AND CARING INC
1986 DALLAS DR/STE 4
BATON ROUGE LA 70806

PROVIDER NUMBER 1464384

DEAR PROVIDER,

THE RECIPIENT'S REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN PAR TIAL L Y DE NI ED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

-----------------------------------------------

PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN REQUESTED: 2086
APPROVED: 1660
DIFFERENCE: 426
DATES OF SERVICE: 05/14/2009 - 11/13/2009 STATUS: PARTIALLY DENIED

-----------------------------------------------

THIS REQUEST IS RE-REVIEWED WITH MD'S LETTER. BASED ON THE NEW INFORMATION WE HAVE APPROVED THIS REQUEST FOR 3 HOURS A DAY, 5 DAYS A WEEK FOR 26 WEEKS OF PERSONAL CARE SERVICES. THIS REQUEST IS APPROVED AS FOLLOWS:

30 MINUTES FOR BATHING
30 MINUTES FOR DRESSING
30 MINUTES FOR GROOMING
30 MINUTES FOR TOILETING
30 MINUTES FOR EATING
30 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES
IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.

IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/25/2009 PROVIDER NAME SHARING AND CARING I
PRIOR AUTH. NBR PROVIDER NUMBER 1464394

************************
* THIS IS NOT A BILL *
************************

RECIPIENT NUMBER
CCN NUMBER

GEAR 1

YOUR REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

PARTIALLY DENIED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

-----------------------------------------------

PROCEDURE: T1019 EP PERSONAL CARE SERVICE, EACH 15 MIN
REQUESTED: 2096
APPROVED: 1560
DIFFERENCE: 536

-----------------------------------------------

THIS REQUEST IS RE-REVIEWED WITH MD'S LETTER. BASED ON THE NEW INFORMATION
WE HAVE APPROVED THIS REQUEST FOR 3 HOURS A DAY, 5 DAYS A WEEK FOR 28 WEEKS
OF PERSONAL CARE SERVICES. THIS REQUEST IS APPROVED AS FOLLOWS:

30 MINUTES FOR BATHING
30 MINUTES FOR DRESSING
30 MINUTES FOR GROOMING
30 MINUTES FOR TOILETING
30 MINUTES FOR EATING
30 MINUTES FOR INCIDENTAL HOUSEHOLD SERVICES

YOU MAY HAVE YOUR CASE MANAGER ASSIST YOU WITH OBTAINING MEDICAID SERVICES. IF
YOU DO NOT HAVE A CASE MANAGER AND WOULD LIKE TO OBTAIN ONE, YOU SHOULD CALL
STATISTICAL RESOURCES, INC (SRI) AT 1-800-364-7828.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING
ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.
IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

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SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P.O. BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/26/2009

PRIDR AUTH. NBR 

DELAUNES FAMILY DRUG STORE
308 N LEWIS
NEW IBERIA LA 70563

PROVIDER NUMBER 1215210

DEAR PROVIDER,

THE RECIPIENT'S REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN DENIED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

-----------------------------------------------------------------------------------------------------------------------
PROCEDURE: A6251 ABSORPT DRG <=16 SQ IN W/O B
REQUESTED: 132.00 APPROVED: 0.00
DATES OF SERVICE: 06/01/2009 - 11/30/2009 STATUS: DENIED
-----------------------------------------------------------------------------------------------------------------------

THE FOLLOWING REQUEST IS DENIED BECAUSE THE PROVIDER, RECIPIENT AND OR THE CASE MANAGER FAILED TO RESPOND TO THE NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION. THE DATE ON THE NOTICE THAT WAS SENT OUT WAS DATED 06/22/2008. PLEASE NOTE THAT THE FOLLOWING INFORMATION IS NEEDED FOR A DETERMINATION TO BE MADE ON THE REQUESTED SERVICES FOR STERILE GAUZE:

1. SUBMIT WHAT THE STERILE IV GAUZE IS BEING USED FOR.
2. IF THE GAUZE IS BEING USED FOR THE GASTRO-TUBE THEN NEEDS TO SUBMIT CORRECT PROCEDURE CODE FOR THAT GAUZE.
3. SUBMIT A LETTER OF MEDICAL NECESSITY FROM THE PHYSICIAN AS TO WHY IV STERILE GAUZE ARE NEEDED FOR GASTRO-TUBE SITE.

IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE PCP REFERRAL NUMBER ON THE CLAIM IN ORDER TO BE REIMBURSED BY MEDICAID.
STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P.O. BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 06/26/2009

PROVIDER NAME DELAUNES FAMILY DRUG

PRIOR AUTH. NBR

PROVIDER NUMBER 1215210

* THIS IS NOT A BILL *

RECIPENT NUMBER

CCN NUMBER

DEAR:

YOUR REQUEST FOR PRIOR AUTHORIZATION OF SERVICE(S) HAS BEEN

DENIED.

THE FOLLOWING SERVICE(S) WAS REQUESTED THROUGH OUR PRIOR AUTHORIZATION SERVICE

________________________________________________________________________

PROCEDURE: A6251

ABSDRPT DRG <=16 SQ IN W/O B

REQUESTED: 132.00

APPROVED: 00

DATES OF SERVICE: 06/01/2009 - 11/30/2009

STATUS: DENIED

________________________________________________________________________

THE FOLLOWING REQUEST IS DENIED BECAUSE THE PROVIDER, RECIPIENT AND OR THE CASE MANAGER FAILED TO RESPOND TO THE NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION. THE DATE ON THE NOTICE THAT WAS SENT BUT WAS DATED 05/22/2009 PLEASE NOTE THAT THE FOLLOWING INFORMATION IS NEEDED FOR A DETERMINATION TO BE MADE ON THE REQUESTED SERVICES FOR STERILE GAUZE:

1. SUBMIT WHAT THE STERILE IV GAUZE IS BEING USED FOR.
2. IF THE GAUZE IS BEING USED FOR THE GASTRO-TUBE THEN NEED TO SUBMIT CORRECT PROCEDURE CODE FOR THAT GAUZE.
3. SUBMIT A LETTER OF MEDICAL NECESSITY FROM THE PHYSICIAN AS TO WHY IV STERILE GAUZE ARE NEEDED FOR GASTRO-TUBE SITE.

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IF YOU DISAGREE WITH OUR DECISION, YOU HAVE THE RIGHT TO APPEAL, AND MAY BRING ADDITIONAL EVIDENCE TO THE HEARING TO SUPPORT YOUR REQUEST FOR SERVICES.

IN ORDER TO APPEAL, PLEASE WRITE TO:

OFFICE OF THE SECRETARY
BUREAU OF APPEALS
P.O. BOX 4183
BATON ROUGE, LA 70821-4183

YOUR REQUEST FOR APPEAL MUST BE RECEIVED OR POSTMARKED WITHIN 30 DAYS OF THE NOTICE DATE.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
IF CLARIFICATION ON THIS DECISION IS NEEDED, CONTACT THE PRIOR AUTHORIZATION UNIT AT UNISYS 1-800-488-6334.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
NOTICE OF INSUFFICIENT PRIOR AUTHORIZATION DOCUMENTATION

RECIPIENT: 
DATE OF NOTICE: 4/30/2015

CASE MANAGER: 
PROVIDER: GOLDEN PATIENT CARE SERVICES

DATE OF REQUEST: 03/10/2015

DATE OF SERVICE REQUESTED:
Began: 03/09/2015  Ended: 09/06/2015

SERVICE REQUESTED: Personal Care Services
PA NUMBER: 507057006

The following documentation and/or information are still needed in order to complete your prior authorization request.

The following information is needed so a determination can be made for Personal Care Services for [Insert Name]. Please submit the following item(s).

1. The Form 90 is incomplete. Please complete and submit the Form 90. The following sections are incomplete: The Medical Information on the 1st and 2nd page.
2. The Form 90 needs to be signed and dated by the physician.

Golden Patient Care Services and Easier Seals Louisiana (case manager) can assist the recipient in obtaining the requested information.

The following provider can provide this information:

(If you need help finding such a provider, contact Specialty Care Resource line toll free at 877-455-9955 for the name, address and phone number of such a provider in your area.)
[This form tells the provider what information is needed. You can give this form directly to him or her.]

If you, your case manager, or any health professional have questions, please call (800) 807-1320 and press option 2 to reach the Prior Authorization Liaison (PAL).

WE WILL DENY YOUR PRIOR AUTHORIZATION REQUEST UNLESS:

MOLINA MEDICAID SOLUTIONS
ATTN: PRIOR AUTHORIZATION LIAISON
P. O. BOX 14919 * BATON ROUGE, LOUISIANA 70898-4919
PHONE: 800/807-1320 * FAX: 225/216-6478
YOU NOTIFY THE PAL IN WRITING, WITHIN 30 DAYS OF THE DATE ON THIS NOTICE, ABOUT AN APPOINTMENT YOU MADE WITH A HEALTH CARE PROVIDER OF THE TYPE WE SPECIFIED, AND YOU ATTEND THE APPOINTMENT, OR

WE HAVE RECEIVED ALL NEEDED DOCUMENTATION WITHIN 30 DAYS.

If you need help scheduling an appointment with a health care professional or transportation to the appointment, you can contact your case manager or contact Specialty Care Resource line at 877-455-9955. YOU MUST complete and return the form below to notify the PAL if you make an appointment to provide the necessary information described in this notice.

I HAVE AN APPOINTMENT WITH ____________________________
PROVIDER'S NAME

THE DATE OF MY APPOINTMENT IS ________________, 200__.

_________________________________  ____________________________
Your Name                                    Medicaid ID Number

SEND THIS FORM TO THE PRIOR AUTHORIZATION LIAISON:
Name: Prior Authorization Liaison
Address: P. O. Box 14919 Baton Rouge, LA 70898-4919
Phone: (800) 807-1320/option 2
Fax: (225) 216-6478
MEMORANDUM

TO: ESPDT Support Coordination Agencies

FROM: Ellen Bachman

SUBJECT: Modification of Rehab Services PA Tracking/PAL Referral

DATE: March 11, 2011

We are aware that a number of community therapy providers (OT, PT, and ST rehab services) are not submitting their PA requests to Molina, but are delivering services to the EPSDT clients. The providers can wait a year to bill Medicaid for services and some are waiting until then to submit the PA requests. The PA tracking procedure has been modified for these cases.

When Support Coordinators are tracking rehab services (OT, PT, ST) they do not always need a PA. Prior to completing a 35 or 60 day PAL Referral the Support Coordinator is to contact the provider to confirm if the participant is receiving the service. If the provider confirms that service is being delivered, the family is to be contacted to also confirm the delivery of services. If BOTH the family and provider confirm that the client is receiving the prescribed therapy, a PAL referral would not be needed. The Support Coordinator must document this confirmation in the service log and in the note box of the PA tracking log. PAL referrals and continued PA tracking would not be needed. The Support Coordinator will need to ensure the client continues to receive the requested services though monthly contact with the family/participant.

If the Support Coordinator cannot confirm that services are being provided and there is no PA in place, the coordinator must initiate a PAL referral within the prescribed timelines. If the PAL can confirm with the family and provider that the services are being delivered, the PAL will contact the Support Coordinator to inform the Support Coordinator that services are being delivered and provide them with the date services began. The Support Coordinator is to document the PAL’s notification in the service log and PA tracking log note box. Continued PA Tracking is not needed. The Support Coordinator will need to ensure the client continues to receive the requested services though monthly contact with the family/participant.

If the Support Coordinator receives a PA notice, it is to be entered on a tracking log and PA Tracking will restart.

Revised 3/11/11
Revised 3/31/14, 4/27/16
Referral to Medicaid PAL
EPSDT - Targeted Population

Date:

TO: Medicaid Prior Authorization Liaison (PAL) · P.O. Box 91030 · Baton Rouge, LA · 70821-9030

Attn: Nancy Spillman · Fax 225-389-2749

<table>
<thead>
<tr>
<th>FROM:</th>
<th>Support Coordinator’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider #:</td>
<td>Support Coordinator’s Phone#:</td>
</tr>
<tr>
<td></td>
<td>Fax#:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RE: State Plan Provider:</th>
<th>Provider #:</th>
<th>Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
<td>State/Zip:</td>
</tr>
</tbody>
</table>

Service Type (if DME be specific): |
| Service Name: |
| Amount/# of Hours of Service: |
| ( ) Initial ( ) Renewal |

<table>
<thead>
<tr>
<th>Participant Name:</th>
<th>MID#:</th>
<th>Phone#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Party:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address: |
| City: | State/Zip: |

This is to inform you that this individual is receiving EPSDT - Support Coordination Services and we are having/had the following problem with the Medicaid State Plan Provider identified above (only those requiring PA): (Check the following that apply.)

1. The provider has not submitted the PA packet within 35 calendar days from the date of the provider’s receipt of referral.

2. We have not received an approval within 60 days from the Choice of Provider date.

3. The participant has been advised of their right to choose another provider and we are beginning the process again.

4. The participant has been advised of their right to choose another provider but has decided to stay with the same provider and wait until the PA packet is submitted.

5. We have not received a notice of approval from Molina for the renewal approval and the previous PA expired on ___/___/____ .

6. The provider is not providing services at the times the participant requested and we have been unable to resolve the issue.

7. The provider is not providing the amount of services as per the CPOC and as prior authorized and we have been unable to resolve the issue.

8. The participant has been unable to locate an in-home service provider (PCS or EHH).

9. Other:

Attached are the EPSDT Prior Authorization Tracking Log and the supporting EPSDT Service Logs that document the contacts made regarding the issues identified above. (This documentation must be sent with this form letter.)

Support Coordinator’s Signature _______________________ Date ________________

Revised 6/18/15, 8/7/15, 12/22/15, 4/26/18
### Legacy Medicaid

#### EPSDT Timeline & Documentation

#### Participant Contacts

<table>
<thead>
<tr>
<th>Support Coordination Referrals</th>
<th>Case Maintenance</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within 3 working days:</strong> Phone contact or Face-to-face Visit for Intake (Document on EPSDT Service Log)</td>
<td><strong>As Needed</strong> Follow up on obtaining information to submit or obtain approval of a PA request. Determine service start date after PA notice received. Assist with identified needs and problems with providers (Document on EPSDT Service Log &amp; PA Tracking Log as needed)</td>
<td><strong>Within 4 calendar days from notice of denial:</strong> Explain appeal rights &amp; offer assistance Explain that the provider can request a reconsideration (Document on PA Tracking Log &amp; EPSDT Service Log)</td>
</tr>
<tr>
<td><strong>Within 10 calendar days:</strong> Face-to-face in-home visit for Assessment (Document on EPSDT Service Log)</td>
<td><strong>Monthly Contacts</strong> Assure implementation of requested services listed on the CPOC (Document on PA Tracking Log and EPSDT Service Log)</td>
<td><strong>20 days from date appeal request filed:</strong> Check on appeal status and if additional assistance is needed with the appeal. (Document on PA Tracking Log &amp; EPSDT Service Log)</td>
</tr>
<tr>
<td><strong>Within 35 calendar days:</strong> Complete and submit an approvable CPOC to SRI (EPSDT Checklist)</td>
<td><strong>Quarterly Contacts</strong> Face-to-face visit Review CPOC, Status of services &amp; service needs (Document on LSCIS Quarterly Review/ Checklist &amp; Progress Summary and Service Log)</td>
<td><strong>90 days from date appeal request filed:</strong> Check on final outcome of appeal (Document on PA Tracking Log &amp; EPSDT Service Log)</td>
</tr>
</tbody>
</table>

Revised 3.13.19
Legacy Medicaid
EPSDT Timeline & Documentation
Provider Contacts

Within 3 calendar days from date of choice of provider:
Send referral to provider
(Use Referral to Provider Form & Document on PA Tracking Log and EPSDT Service Log)

Within 15 calendar days from date of referral to provider:
Contact provider to check on status of referral & offer assistance if needed.
(Document on EPSDT Service Log)

Within 35 calendar days from date of referral to provider:
Contact provider to check on status of referral and offer assistance if needed. If PA Packet has not been sent to Molina send Referral to PAL and continue to follow up with provider until packet has been submitted.
(Document on EPSDT Service Log.)

10 calendar days from date provider sent referral to Molina:
(25 days if a DME request)
If PA or PAL Notice not received contact provider to follow up on status of PA. Continue to follow up until PA is approved or denied based on medical necessity.
(Document on EPSDT Service Log)

45 – 60 days prior to end of PA period:
Send reminder notice to provider to renew PA
(Complete Referral to Provider Form & Document on PA Tracking Log & EPSDT Service Log)
# Legacy Medicaid

## EPSDT Timeline & Documentation

### PAL Referrals

### 35 Day and 60 Day PAL Referrals

<table>
<thead>
<tr>
<th>35 calendar days from date of provider referral:</th>
<th>If provider has not sent PA Packet to Molina, Send referral to PAL using Referral to PAL Form (Document on PA Tracking Log &amp; EPSDT Service Log)</th>
</tr>
</thead>
</table>

| 60 calendar days from participant’s date of choice of provider: | If PA approval/denial has not been received, Send referral to PAL using Referral to PAL Form (Document on PA Tracking Log & EPSDT Service Log) |

### Other PAL Referrals

<table>
<thead>
<tr>
<th>If PA Renewal Approval Not Received:</th>
<th>Complete Referral to PAL Form, (Document on PA Tracking Log &amp; EPSDT Service Log)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If Participant Chooses a New Provider:</th>
<th>Complete Referral to PAL Form, (Document on PA Tracking Log &amp; EPSDT Service Log)</th>
</tr>
</thead>
</table>

| If Service not provided in the amount in PA or Service not at times according to PA | Complete Referral to PAL Form, (Document on PA Tracking Log & EPSDT Service Log) |
|-------------------------------------------------------------------------------------|

| Unable to find a provider that is willing to submit a request for a PA* | Complete Referral to PAL Form, (Document on PA Tracking Log & EPSDT Service Log) |
|------------------------------------------------------------------------|

*Fee for Service Contact the LDH Staff Line for PCS and EHH
RECIPIENT’S CONSENT
FOR AUTHORIZED REPRESENTATION

Recipient’s Name ________________________________________________

SSN # __________________________________________________________

ID# __________________________________________________________________

I understand that all information gathered, on my behalf and/or for those persons for whom I am responsible, is personal and confidential. I understand that the function of the Authorized Representative is to represent me in the Comprehensive Plan of Care (CPOC) process and to sign CPOC documents on my behalf. I also understand that my authorized representative has the power to make decisions for me concerning all aspects of various Medicaid services administered by the Louisiana Department of Health (LDH). I understand this may require the Department to disclose information to the representative named below that may otherwise be confidential. I hereby waive any rights I may have to prevent disclosure by the Department to the authorized representative named below.

I understand that this authorization is limited solely to the individual named below and is valid until revoked by me. I further understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative at any time upon written notice to the Department.

I understand that while some of the information gathered may have no impact on Medicaid services received, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Louisiana Department of Health (LDH) harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.
NOTE:
If the participant is a competent major and the authorized representative is being contacted and followed up with instead of the participant, there must be documentation to support the participant’s request to have the authorized representative contacted or documentation of the participant’s inability to self-direct their care.

Authorized Representative Name: ___________________________________________
Address: ________________________________________________________________
Telephone Number (Home): ____________________ (Work) _____________________
Authorized Representative Signature: _________________________________________
Date: _______________________________

Recipient’s Signature: _____________________________ Date:___________________
Witness’ Signature: _______________________________ Date:_________________
Support Coordinator’s Signature: ____________________ Date: ___________________
STATE OF LOUISIANA
PARISH OF ___________________

Non-legal Custodian’s Affidavit

Use of this affidavit is authorized by R.S. 9:975.

Instructions: Completion of items 1 through 4 and the signing of the affidavit are sufficient to authorize educational services and school-related medical services for the named child. Completion of items 5 through 8 is additionally required to authorize any other medical services. Please print clearly or type.

The child named below lives in my home and I am at least 18 years of age.

1. Name of child: ____________________________________________
2. Child’s date of birth: ________________
3. Name of adult giving authorization: __________________________
4. Adult’s home address: ______________________________________
   __________________________________________
5. [ ] I am a non-legal custodian.
6. Check one or both (for example, if one parent was advised and the other cannot be located):
   [ ] I have advised the parent(s) or legal custodian(s) of the child of my intent to authorize the rendering of educational or medical services, and have received no objections.
   [ ] I am unable to contact the parent(s) or legal custodian(s) of the child at this time to notify them of my intended authorization.
7. Adult’s date of birth: ________________
8. Adult’s Louisiana driver’s license or identification card number: __________________

WARNING: Do not sign this form if any of the above statements are incorrect, or you will be committing a crime punishable by fine, imprisonment, or both.
I declare under penalty of perjury under the laws of Louisiana that the above statements are true and correct.

Signed:  

Date:  

NOTICES:

1. This declaration does not affect the rights of the child’s parent or legal guardian regarding the care, custody, and control of the child, and does not mean that the non-legal custodian has legal custody of the child.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year from the date on which it was executed.

ADDITIONAL INFORMATION:

TO NON-LEGAL CUSTODIANS:

1. If the child stops living with you, you are required to notify anyone to whom you have given this affidavit as well as anyone of whom you have actual knowledge who received the affidavit from a third party.

2. If you do not have the information in item 8 (Louisiana driver’s license or identification card), you must provide another form of identification, such as a social security card.

TO SCHOOL OFFICIALS:

The school district may require additional reasonable evidence that the non-legal custodian lives at the address provided in item 4, such as a recent bill.

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. No person who acts in good faith reliance upon a non-legal custodian’s affidavit to render educational or medical services, without actual knowledge of facts contrary to those stated in the affidavit, is subject to criminal prosecution or civil liability to any person, or subject to any professional disciplinary action, for such reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.

Sworn to and subscribed before me, NOTARY PUBLIC, on this _______ day of ______________, 200__, at ______________, Louisiana.

 ____________________________

Name of Notary Public:
EPSDT Quarterly Report Checklist

Fax to SRI, Attn: Kim Willems at 225-767-0502 or e-mail to ksalling@statres.com by the 5th day of the month following the end of each quarter.

<table>
<thead>
<tr>
<th>SC Agency</th>
<th>Region</th>
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<tr>
<th>✓</th>
<th>Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarterly Report (Print Out from LSCIS)</td>
</tr>
<tr>
<td></td>
<td>Number of trackable service needs matches number of service needs being tracked.</td>
</tr>
<tr>
<td></td>
<td>Number of trackings without a date of choice of provider is zero or documentation and explanation is attached to the Quarterly Report.</td>
</tr>
<tr>
<td></td>
<td>Quarterly Report of CPOC Revisions (Appendix W-2)</td>
</tr>
<tr>
<td></td>
<td>Service Needs Changes Report attached <em>(the report does not need to be written onto Appendix W-2; just attached)</em></td>
</tr>
<tr>
<td></td>
<td>Record Reviews (Appendix W-3)</td>
</tr>
<tr>
<td></td>
<td>For all PAs not Issued within 60 days</td>
</tr>
<tr>
<td></td>
<td>For all Gaps in PA Authorization Periods</td>
</tr>
<tr>
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<td>If deficiencies were found in required contacts, timelines, follow up, documentation, etc. the agency will submit a Corrective Action Plan within 7 days and documentation that the Corrective Action Plan was carried out within 14 days.</td>
</tr>
<tr>
<td></td>
<td>Training Log (Appendix W-4)</td>
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<td></td>
<td>For all new hires or new EPSDT Supervisors for the quarter</td>
</tr>
</tbody>
</table>

Your signature below indicates that the packet has been reviewed by your agency for completeness and that all required information is being submitted for review.

Signature of SCA Representative: __________________________ Date: __________

Issued 4.2.19
Quarterly Report of CPOC Revisions

Complete the following information for your agency for all EPSDT participants and e-mail to BHSF/SRI (ksalling@statres.com) by the 5th day of the month following the end of each quarter. The reporting information should reflect activities that occurred between the first and last day of the quarter. Attach a print out of the Service Needs Changes report from LSCIS.

Support Coordination Agency:______________________________ Region:_________________
Quarter/Year:____________________

<table>
<thead>
<tr>
<th>Participant</th>
<th>Revision Date</th>
<th>Item, Information, or Service Revised</th>
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</table>
Record Review for EPSDT Quarterly Reports - Gap in PA Periods or PA not Issued within 60 Days

Agency/Region____________________________________ Quarter/Year____________________________
Participant________________________________________ SC Assigned to Case_____________________
Service__________________________________________ SC Supervisor__________________________

Gap in Authorization Period
Are the “Date of Service Request” and renewal "Choice of Provider" dates correct on
the PA Tracking Logs?

1 PA end date on the prior PA Tracking ________

2 PA start date on the current PA notice ________

3 Gap consisted of how many days__________

4 Was the service provided during the Gap?

5 Was the gap due to the family choice? If so, explain. (If yes, don't include it on the report.)

6 Was the referral to the provider/MMCCM for the PA renewal sent 45-60 days prior to the PA expiration for Legacy or 20-60 days prior for Medicaid Managed Care?

PA Not Issued Within 60 Days
7 Was the PA received?

8 Date Received ______________

9 PA Decision Date ____________

10 Approval Status: Full Approval_____ Partial Approval_____ Partial Denial_____ Denied_____

11 Summary of Reason PA was not Issued Within 60 Days:
<table>
<thead>
<tr>
<th>Required review for “PAs not issued within 60 days” and “Gaps in Authorization Periods”</th>
<th>Yes</th>
<th>No</th>
<th>Supporting Document and Service Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Is the PA “type of request” correctly identified on the PA Tracking Log?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Did PA tracking begin with the initial request date documented in the Service Logs or Quarterly Review? (Review Service Logs and Quarterly Reviews prior to the request date listed on the tracking log to ensure this is the initial request date.)</td>
<td></td>
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</tr>
<tr>
<td>14</td>
<td>Was the family informed that a prescription was required and given the forms to be completed by the physician? Was assistance offered in scheduling appointment if it is required for the prescription?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Is there documentation of timely assistance with the FOC and participant/guardian follow up to obtain a COP?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>If a provider could not be found, is there documentation of attempts to locate a provider and LDH Staff Line/PAL contact if needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Was the Referral to the Provider/Medicaid Managed Care Case Manager(MMCCM) made within 3 days of the COP/Date of Service Request?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Is there documentation of a provider/MMCCM contact within 15 days of the referral to check on the status of the referral and offer assistance if needed? (Service Log and PA Tracking Log)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Is there documentation that the SC followed up with the family to see if the provider contacted them and if they contacted the physician or obtained the prescription?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Is there documentation of a provider/MMCCM contact within 35 days of the referral to the provider/MMCCM to check on the PA status?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Was the PA packet submitted to Molina or the MCO within 35 days of the referral?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>If not, why?</td>
<td></td>
<td></td>
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<tr>
<td>23</td>
<td>Was there a barrier?</td>
<td></td>
<td></td>
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<tr>
<td>24</td>
<td>Did the SC assist in identifying and removing the barrier?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25</td>
<td>Was the 35 day PAL referral completed timely? (Not required for Medicaid Managed Care Program)</td>
<td></td>
<td></td>
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<tr>
<td>26</td>
<td>Was an offer to switch providers made and documented?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>27</td>
<td>If the PA request was submitted, was the PA packet requested and/or received?</td>
<td></td>
<td></td>
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<tr>
<td>28</td>
<td>Was the “date packet submitted to Molina/MCO” entered on the PA Tracking Log?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required review for “PAs not issued within 60 days” and “Gaps in Authorization Periods”</td>
<td>Yes</td>
<td>No</td>
<td>Supporting Document and Service Date</td>
<td>Comments</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Is there documentation of a follow up with the provider/MMCCM 10 days after the PA request was submitted (25 days for DME)?</td>
<td></td>
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</tr>
<tr>
<td>If the PA was not received, was the 60th day PAL referral timely?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Is there documentation of ongoing contact with the participant/guardian and provider until the PA notice is received or the service request is resolved?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the SC follow up and do planned activities and contacts as documented in the Service Logs, Quarterly Reviews or CPOC. Is there documentation of the planned actions, contacts and follow up?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Was there adequate SC supervision to ensure the required contacts, PA tracking and follow ups were completed timely and assist the SC with problem solving?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of PA decision</td>
<td>Date of PA Decision:</td>
<td>*If a PA has not been received, submit notification to <a href="mailto:ksalling@statres.com">ksalling@statres.com</a> when the PA is received or the requested service is resolved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the PA has not been received, what action will the SC take to obtain the PA? What is the barrier and how will it be removed? Frequent follow up is required.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Were deficiencies found in the required contacts, timelines, follow up, documentation, etc.? If so, the agency will submit a Corrective Action Plan within 7 days.</td>
<td></td>
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</tr>
<tr>
<td>Documentation that the Corrective Action Plan was carried out will be submitted within 14 days.</td>
<td></td>
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</tr>
</tbody>
</table>

EPSDT Specialist Signature *Cannot be the SC assigned to the case

_______________________________________________________

Date___________________

EPSDT Specialist’s Supervisor Signature

_______________________________________________________

Date___________________

On-Site Program Manager’s Signature

_______________________________________________________

Date___________________

Revised 3/13/19
### 2019 EPSDT Training

<table>
<thead>
<tr>
<th>Project:</th>
<th>EPSDT Support Coordination Training</th>
<th>Agency/Region</th>
</tr>
</thead>
</table>

I viewed the 2019 EPSDT Support Coordination Training Module with the trainer and read the entire 2019 EPSDT Support Coordination Training Handbook and Appendices to complete the required Annual EPSDT Support Coordination training.

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature (Agrees with the above statement)</th>
<th>Position</th>
<th>Does the SC have EPSDT cases?</th>
<th>Date Training Module Completed</th>
<th>Date Handbook and Appendices Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

I certify that training provided contained all necessary information to assure the individual is knowledgeable of the services available to EPSDT eligible individuals.

Signature of Trainer

Date:_____________________

*Please submit a print out of your **Staff List Report** from LSCIS with the completed **Training Log**. All active **EPSDT SCs, Supervisors and the Trainer** are to receive the annual EPSDT training following the annual training at LDH.

*All new hires are to receive the training as part of their orientation and prior to being assigned an EPSDT caseload or prior to beginning supervision of EPSDT Support Coordinators. Please submit documentation of new hire training with the Quarterly Report or as it is completed.*
This checklist identifies the forms that are to be sent to BHSF/SRI for review and approval. The documents are to be sent immediately after submission of the plan of care in LSCIS for all Initial plans of care and all plans of care identified as “Special Needs.” Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems.

<table>
<thead>
<tr>
<th>FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Formal Information Documents</strong></td>
</tr>
<tr>
<td>• An initial CPOC requires all assessments/evaluations and supporting documents from the regional OCDD office in addition to current formal documents. These must be sent to SRI to receive approval of an initial CPOC.</td>
</tr>
<tr>
<td>• A CPOC flagged as “Special Needs” requires all of the current formal information documents be sent to SRI to receive approval.</td>
</tr>
<tr>
<td><strong>SOA and/or Participant Recap Sheet</strong> (if an Initial CPOC)</td>
</tr>
<tr>
<td><strong>LSCIS CPOC Signature Page</strong> (With planning participant’s signatures, participant/guardian’s CPOC approval signature, and the SC &amp; SC Supervisor signature.)</td>
</tr>
<tr>
<td><strong>Typical Weekly Schedule</strong></td>
</tr>
<tr>
<td><strong>EPSDT Rights &amp; Responsibilities</strong> (Just the signature sheet)</td>
</tr>
<tr>
<td><strong>Legal Guardianship Document, Power of Attorney, Non-Legal Custodian Affidavit, or an Authorized Representative Form</strong> (Required if the recipient is interdicted, if the recipient has given power of attorney to another person, or if the legal guardian is not the parent. An authorized representative form needs to be on file if the participant is a competent major and he or she does not sign the CPOC documents or if he or she is not the contact for monthly phone calls.)</td>
</tr>
<tr>
<td><strong>Individualized Education Plan</strong> (If receiving Special Education currently)</td>
</tr>
<tr>
<td><strong>Extended Home Health Plan of Care</strong> (If receiving EHH currently)</td>
</tr>
<tr>
<td><strong>Pediatric Day Healthcare Plan of Care</strong> (If receiving PDHC currently)</td>
</tr>
</tbody>
</table>

The following is a list of common EPSDT Support Coordination CPOC deficiencies:

- It is not noted in the CPOC what current formal documentation you have to support the ICD-10 diagnosis. (Example: must state, “3.13.19 IEP documents developmental delay.”)
- For services that typically require PA tracking, a valid reason is not given for why the service need is not being tracked or how the SC will ensure the service continues to be received.
- Participant’s identified needs are not addressed.
- Discrepancy in the information documented within the CPOC sections. Remove information that is no longer accurate.

YOUR SIGNATURE BELOW INDICATES THAT THE PACKET HAS BEEN REVIEWED BY YOUR AGENCY FOR COMPLETENESS AND THAT ALL REQUIRED INFORMATION IS BEING SUBMITTED FOR REVIEW BY LDH-BHSF.

SIGNATURE: __________________________________________________________ DATE: ____________

SUPPORT COORDINATION AGENCY REPRESENTATIVE
This checklist identifies the forms that are to be sent to BHSF/SRI for review and approval if the annual CPOC is selected for CPOC Monitoring after submittal in LSCIS. Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems.

<table>
<thead>
<tr>
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</tr>
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<tbody>
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YOUR SIGNATURE BELOW INDICATES THAT THE PACKET HAS BEEN REVIEWED BY YOUR AGENCY FOR COMPLETENESS AND THAT ALL REQUIRED INFORMATION IS BEING SUBMITTED FOR REVIEW BY LDH-BHSF.

SIGNATURE:_________________________________________ DATE:____________________
SUPPORT COORDINATION AGENCY REPRESENTATIVE
Appendix Y

Dear Recipient:

Enclosed is a card to keep that has phone numbers to call for assistance.

This is to let you know that if you feel you need a Medicaid covered service that requires prior approval, but providers of the service have refused to submit your request, you may request a “Review of Possible Eligibility” for the services. This review is available only if two (2) providers have refused to submit your full request, or if there is no other provider from whom to request the service.

To submit your request for a review, simply fill out the bottom of this form and send it to the address listed below. A physician’s written statement as to why the services are necessary must be attached to the request. Medicaid will rule on whether you might be eligible for the service you are seeking. If you might be eligible Medicaid will find a provider to submit the request for you.

This option is only available to Medicaid recipients under age 21 who have been on the MR/DD Request for Services Registry on or after October, 1997 (the “Chisholm” class).

The enclosed card has a phone number to call if you need additional forms. You can also obtain them from a Medicaid case manager or from Medicaid’s Prior Authorization Liaison (PAL), who can be reached at 1-800-807-1320.

Sincerely,

Louisiana Department of Health

Name: ___________________________ Medicaid Identification #: _______________________
Social Security #: __________________ Phone Numbers(s): __________________________
How can we contact you? __________________________________________________________
Service(s) being requested: _______________________________________________________

A Doctor’s statement as to why the services are necessary must be attached. Below, you must also list the providers that have refused to submit a request for these services:

Provider 1: __________________________ Name __________________________ Phone Number
Provider 2: __________________________ Name __________________________ Phone Number

Mail to: LDH-PAL
         Post Office Box 91030 Bin #24
         Baton Rouge, Louisiana 70821-9030
# CHOICE of PROVIDER FORM
For EPSDT MEDICAID PROVIDERS

*This form should be used for all Medicaid services requiring prior authorization*

<table>
<thead>
<tr>
<th>Type of Service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Physical Therapy</td>
<td>□ Mental Health Services</td>
</tr>
<tr>
<td>□ Occupational Therapy</td>
<td>□ Dental Services</td>
</tr>
<tr>
<td>□ Speech Therapy</td>
<td>□ Vision Services</td>
</tr>
<tr>
<td>□ Audiology Services</td>
<td>□ Extended Home Health</td>
</tr>
<tr>
<td>□ Medical Equipment (DME)</td>
<td>□ Nutritional Services</td>
</tr>
<tr>
<td>□ Medical Supplies</td>
<td>□ Applied Behavioral Analysis (ABA)</td>
</tr>
<tr>
<td>□ Personal Care Services</td>
<td>□ Other</td>
</tr>
</tbody>
</table>

The participant/family must check the appropriate statement below.

□ My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have reviewed a list of available providers and I understand that this list may not include every available provider. I understand that I may choose a new provider at any time. I have selected the following provider(s). *(Participant/family may choose to list 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> choice.)*

1. ____________________________

2. ____________________________

3. ____________________________

□ My support coordinator has explained to me that I have a choice of service providers when there is a choice available. I have been informed that there is only one (1) provider available for this service. I understand that I may choose a new provider at any time if another provider is available. I have requested that a referral be made to this provider. *(List provider.)*

4. ____________________________

□ I have already chosen the provider that I want. I do not wish to review a list of available providers. I understand that I may choose a new provider at any time. I have requested that a referral be made to this provider. *(List provider.)*

5. ____________________________

Participant/authorized representative must sign and date below.

---

Participant/Authorized Representative ____________________________ Date ____________________________

Relationship to Participant ____________________________

---

Appendix Z

Replaces March 7, 2005 issuance

BHSF-RF-05-002