LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Application Center Monthly Contact

October 18, 2023

Valerie McManus, AC Program Manager

Agenda Items

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

- Clearing Cache
- Open Enrollment
- Verifications
- Mailing Addresses
- Situational Forms
- Status Checks
- Contact Person
- New Resource Options
- Reminders

LOUISIANA DEPARTMENT OF HEALTH

Demonstration-
Clearing Cache in Google Chrome

US Consulting On-screen M WHT_R1.5V_1208.ppt

Clearing Cache (cont.)

LOUISIANA DEPARTMENT OF HEALTH

1.) Select the ⋮ icon in the upper right corner of the screen

2.) Scroll down to “Settings”

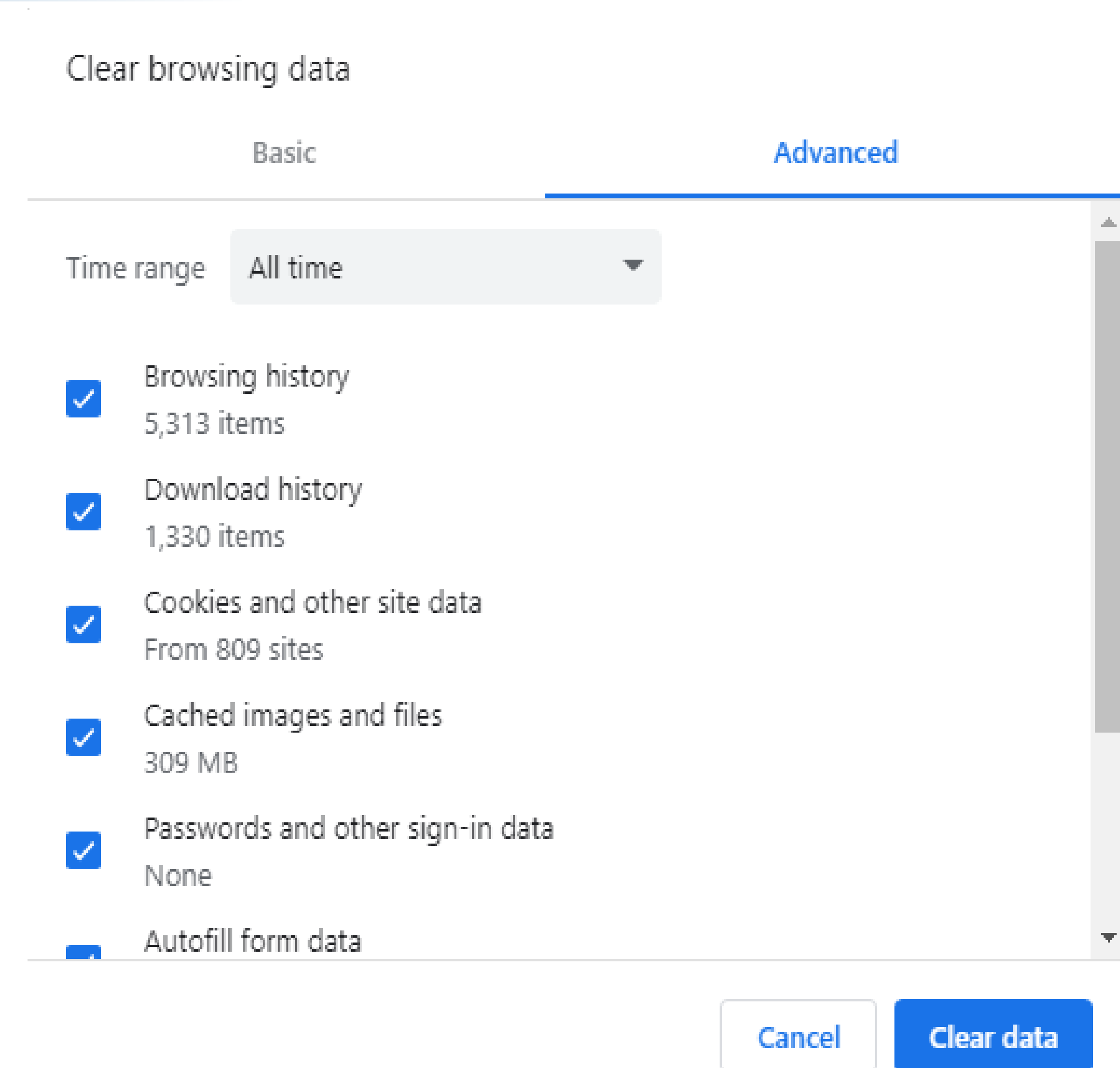
3.) On the Settings screen, click “Privacy and Security” on the right side of the screen.

4.) Click on “Clear browsing data”

5.) Select the tab that says “Advanced” and change the Time Range to “All Time”. Ensure that the first six options are selected then click the Clear data button.

6.) Close your current browser window and open a new one.

7.) Log into your Partner Portal account



Open Enrollment

LOUISIANA DEPARTMENT OF HEALTH

- Medicaid members have the opportunity to change their health or dental plans during Open Enrollment from October 15, 2023, to 6 p.m. on November 30, 2023, with changes becoming effective on January 1, 2024. Staying on their current plan requires no action.

- Changes can be made via mail, fax, the Healthy Louisiana app, myplan.healthy.la.gov, or by calling 1-855-229-6848 from 8am to 5pm. This is the sole time for plan changes without special justification, aside from the initial enrollment period.

US Consulting On-screen M WHT_R1.5V_1208.ppt

Open Enrollment (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- There are six health plans and two dental plans to select from. All offer basic benefits and management programs, with some providing additional services based on age and need.

- Members can see which providers accept their plan by visiting myplan.healthy.la.gov. This information can be accessed by selecting the "Choose" option and clicking "Find a medical or dental provider."

US Consulting On-screen M WHT_R1.5V_1208.ppt

Open Enrollment (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- English, Spanish, and Vietnamese translations of the Open Enrollment flyer have been added to the AC Resource. Please ensure that they are posted in highly visible areas of your facility.

US Consulting On-screen M WHT_R1.5V_1208.ppt

Verifications

- Request identification and income verification at the time of application. If the verifications are available at the time of application, please assist the applicant in sending the information to Medicaid whether via upload, via fax, or via email.
- An application can be still be completed if the applicant does not have the verifications on hand. They can be submitted at a later time.

US Consulting On-screen M WHT_R1.5V_1208.ppt

Mailing Addresses

- Please ensure that a P.O. Box is not listed as a residential address. If the applicant is homeless, please mark that the applicant is homeless and include the mailing address of the local post office as the mailing address.

- The Homeless Address Table has been added to the Forms section of the AC Resource Library for your reference.

US Consulting On-screen M WHT_R1.5V_1208.ppt

Situational Forms

LOUISIANA DEPARTMENT OF HEALTH

- If an applicant alleges a physical, emotional or mental health condition that causes limitations, please ensure that the appropriate situational forms accompany the application.
    - Appendix D
    - BHSF Form MS or MS/C
    - HIPAA 202L or 402P

US Consulting On-screen M WHT_R1.5V_1208.ppt

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

Appendix D

- This form is used to determine resource eligibility.
- It should be completed for anyone that alleges limitations in activities like bathing, dressing, daily chores, etc., lives in a medical facility or nursing home, or is 65 years of age or older.

APPENDIX D

Personal Assets

Complete this appendix if anyone applying has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), lives in a medical facility or nursing home, or is 65 years of age or older.

DOES ANYONE IN YOUR HOME OWN...	ASSET VALUE (closest possible estimate)	DESCRIBE THIS ASSET (include names of banks and other companies)
Checking accounts ☐ Yes ☐ No Who owns this? ______	$ ______	
Savings accounts ☐ Yes ☐ No Who owns this? ______	$ ______	
Vehicles ☐ Yes ☐ No Who owns this? ______	$ ______	
Property other than your home ☐ Yes ☐ No Who owns this? ______	$ ______	
Certificates of Deposit (CDs) ☐ Yes ☐ No Who owns this? ______	$ ______	
Annuities, Trusts, Stocks, Bonds, or Retirement Accounts ☐ Yes ☐ No Who owns this? ______	$ ______	
Life or burial insurance. ☐ Yes ☐ No Who owns this? ______	$ ______	
Money set aside for burial or pre-need contract ☐ Yes ☐ No Who owns this? ______	$ ______	
Safe deposit boxes ☐ Yes ☐ No Who owns this? ______	$ ______	
Other (Please describe in detail) ☐ Yes ☐ No Who owns this? ______	$ ______	

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.dhh.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

US Consulting On-screen M WHT_R1.5V_1208.ppt

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

BHSF Form MS (Social Information Interview Form)- Adult

- This form is used to help Medicaid determine if a person has a disability.
- If an applicant is age 65 or older or has already received a disability decision from the Social Security Administration (SSA), this form does not need to be filled out.

BHSF Form MS
Revised 6/27/14

Social Information Interview Form

A. Instructions

This form is used to help Medicaid determine if you have a disability. If you already have a disability decision from the Social Security Administration (SSA), you do not need to fill this out. Please print clearly and answer all questions.

B. Identifying Information

Name		Today's Date	
Social Security Number	Date of Birth	Age	Sex ☐Male ☐Female

C. Education

Highest Grade Completed	Year you last attended school or a training program	
Were you in special education classes? ☐Yes ☐No	When?	Where?
Did you go to a Vocational school? ☐Yes ☐No	What type?	
Have you had other training? ☐Yes ☐No	What type?	

D. Work History

Tell us about the jobs you've had over the past 15 years.

	Where did you work?	When did you work there? From To	How many hours per week?
1			
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			
2	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			
3	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			
4	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? ☐Yes ☐No	
Describe your major duties at this job			

If you need more space, use a separate piece of paper and attach it.

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

BHSF Form MS/C (Social Information Interview Form)- Child

- This form should be completed by the parent/guardian/care-giver that alleges disability on behalf of their child.

BHSF Form MS/C
Rev. 04-2020
Prior Issue Obsolete

CHILD'S MEDICAL & SOCIAL INFORMATION

(to be completed by parent/guardian/care-giver)

INSTRUCTIONS	► Please fill out completely. **Please Print**. ► Failure to do so may delay the decision.

IDENTIFYING INFORMATION

1. Child's Name: ______ Today's Date: ______
   ❑ Male ❑ Female Age: ___ Height/Weight: ______ Parish of Residence: ______
   Date of Birth: __ __ / __ __ / __ __ __ __ Social Security Number: __ __ __ - __ __ - __ __ __ __

2. Name of person providing information: ______
   Relationship to child: ______

3. Describe the child's condition and how it affects his or her daily activities: ______

4. At what age did the condition begin? ______

5. At what age was the condition first treated? ______

SCHOOL INFORMATION

6. What grade is the child currently attending? ______ Teacher's Name: ______

7. Please list school/preschool information below for the last two years. If more space is required, add additional pages. Attach Individual Education Plan (IEP) or other Pupil Appraisal reports, if any.

Current School Name		Previous School Name	
Address		Address	
City, State		City, State	
Zip Code		Zip Code	
Phone Number	( )	Phone Number	( )
Dates attended		Dates attended	
Any special education services received? ❑ Yes ❑ No	If **yes**, reason for special education:	Any special education services received? ❑ Yes ❑ No	If **yes**, reason for special education:

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

HIPAA 202L

- This form is used to request medical records on the behalf of an applicant.
- A separate form should be completed for each provider that the applicant names.

Louisiana Department of Health and Hospitals
Authorization to Release Health Information
(including paper, oral and electronic information)

DEPARTMENT OF HEALTH AND HOSPITALS

Name:	Social Security #:
Mailing Address:	Date of Birth:
City/State/Zip code:	Telephone #:

I authorize any provider that has treated me or is presently treating me to release requested Protected Health Information (PHI) to:

Agency Name:

Mailing Address:

City/ State/ Zip code :

As the purpose of this authorization is to establish Medicaid eligibility, I authorize the release of all of the following protected health information:
Medical History, Examination, Reports, Surgical Reports, Treatment or Tests, Prescriptions, Immunizations, Hospital Records including Reports, Laboratory Reports, X-ray Reports, DD Records, Discharge summaries

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release any of the following records that are applicable:
Alcoholism, Drug Abuse, Mental Health, Vocational Rehabilitation, HIV (AIDS), Sexually Transmitted Diseases, Genetics, Psychotherapy Notes

I do not authorize the release of the following types of my health information: (If none, leave blank)

____

Please provide medical records for the time period of ________________ **through** ________________.

This authorization to release medical information shall expire on: ______________________.
(date)

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

______________________________________ ____________________
Signature of individual or personal representative authorized by law Date

FOR OFFICE USE ONLY:

Agency Representative:		Date:
Telephone:	Fax:	Email:

HIPAA 202L
Issued 12/11

Situational Forms (cont.)

LOUISIANA DEPARTMENT OF HEALTH

HIPAA 402P

- Used to request specific medical records on behalf of an applicant.
- Submit a separate form for each provider listed.

LOUISIANA DEPARTMENT OF HEALTH

Authorization to Release or Obtain Health Information
(including paper, oral and electronic information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid # or Social Security #

I authorize:

Name: ______________________________

Mailing Address: ______________________________

City, State, Zip Code: ______________________________

Relationship: ______________ Telephone Number: ______________

❐ **TO RELEASE Information TO** OR ❐ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: ______________________________

Mailing Address: ______________________________

City, State, Zip Code: ______________________________

Relationship: ______________ Telephone Number: ______________

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❐ Further Medical Care ❐ Personal ❐ Legal Investigation or Action ❐ Changing Physicians
❐ Research related treatment ❐ Creating health information for disclosure to a third party.
❐ Other: (Specify) ______________________________

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)
❐ Entire Record ❐ Medical History, Examination, Reports ❐ Surgical Reports ❐ Treatment or Tests
❐ Prescriptions ❐ Immunizations ❐ Hospital Records including Reports ❐ Laboratory Reports
❐ X-ray Reports ❐ MR/DD Records ❐ Other: ______________

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
❐ Alcoholism † ❐ Drug Abuse † ❐ Mental Health ❐ Vocational Rehabilitation ❐ HIV (AIDS)
❐ Sexually Transmitted Diseases ❐ Genetics ❐ Psychotherapy Notes
❐ Other ______________

This authorization shall expire on ______________ **(date or event) and is needed for the period beginning** ______________ **and ending** ______________.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

Signature of Individual or Personal Representative Authorized by Law ______________ Date ______________

Signature of Witness *(If signed with an "X" or mark)* ______________ Date ______________

For LDH Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

Signature and Title of Agency Representative ______________ Date ______________

† Provider shall be given a copy of signed document that acknowledges their receipt of Federal Rule 42 CFR § 2.32 - Prohibition on redisclosure.

Status Checks

LOUISIANA DEPARTMENT OF HEALTH

- Outstation Analysts can assist with status checks. If one is assigned to your location, please utilize their services.
- This would help to alleviate the call volume and hold time our Customer Service Unit is experiencing.

Contact Person

- Please ensure that accurate details are provided on applications. An adult should always be listed as the contact person, even if a child is the only applicant.
- If a child is listed as the primary contact, an unnecessary case could be created and cause issues with the household member linkage.

US Consulting On-screen M WHT_R1.5V_1208.ppt

New Resource Options

- The following resource options have been added to the More About Resources section of the general application.
    - Uniform Gifts to Minors Act (UGMA)
    - Uniform Transfers to Minors Act (UTMA)
    - Achieving a Better Life Experience (ABLE)

- These are tax free/sheltered accounts for minors that were set up by parents

US Consulting On-screen M WHT_R1.5V_1208.ppt

New Resource Options (cont.)

- UGMA, UTMA, and ABLE resource categories are as follows:

• Life Insurance (Burial, Whole, Term)	• Mortgage or Promissory Note
• Cash	• Retirement Account
• Home Property	• Burial Contract, Plot, or Space
• Property other than where you live	• Vehicles
• Bond for Deed	• Safe Deposit Box
• Annuity	• Trust
• Escrow Account	

New Resource Options (cont.)

LOUISIANA DEPARTMENT OF HEALTH

- This is an example of the More About Resource screen. Only one resource can be selected at a time.

More About Resources

You have told us that has resources. Please answer the questions below to tell us more about these resources.

RESOURCE DETAILS

Category: Cash

- [x] Is this a Uniform Gifts to Minors Act (UGMA) or Uniform Transfers to Minors Act (UTMA) account?
- [ ] Is this an Achieving a Better Life Experience (ABLE) account?

Reminders

LOUISIANA DEPARTMENT OF HEALTH

- AC Resource Library – Check it DAILY
- Ensure you log into the PARTNER portal and not the Public or Provider portal.
- Adhere to Medicaid guidelines
- Trusted Users must conduct Face-to-Face interviews
- For issues with newborns, email NEU@la.gov
- EMS
  - Submit medical records immediately upon receiving the denial due to non-citizenship. They should be sent to the EMS Rightfax (225) 389-2748 (Local) or (877) 747-0996 (Toll-free).
  - For aged EMS claims, email the EMS Aged Claims Status Request form (on the AC Resource Library) to MEDT-EMS@la.gov.
- AC Meetings are conducted on your behalf. Attendance is required and participation is encouraged.

Contact Information

Application Centers (AC)

- ApplicationCenter.Service@la.gov
- (225) 342 – 6312
- Valerie McManus

Medical Eligibility Determinations Team (MEDT)

- MEDT@la.gov
- Angel Wilson Jolivette

Newborn Eligibility Unit (NEU)

- NEU@la.gov
- Kiarah Dugas

Medicaid Outreach

- MedicaidOutreach@la.gov

Optional State Supplement (OSS)

- OSS@la.gov
- (225) 342 – 1646
- Paige Logan

Outstation

- Outstation@la.gov
- (225) 342 – 1646
- Paige Logan

Healthy Louisiana

- 1-855-229-6848

Louisiana Medicaid Customer Service

- 1-888-342-6207

Questions

US Consulting On-screen M WHT_R1.5V_1208.ppt