PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Substitute Family Care

(Enrollment packet is subject to change without notice)
GENERAL INFORMATION FOR THE SUBSTITUTE FAMILY CARE PROVIDER TYPE

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re-submission of the enrollment packet is subject to an additional three-week turnaround period.

Effective date of enrollment will be the date the application is actually worked up by Provider Enrollment.

A separate enrollment packet must be completed for each LDH Administrative Region in which your agency will be providing services as a Substitute Family Care provider.

The following individual licensed Provider Types may be linked and reimbursed through the Substitute Family Care provider type, for the purpose of providing ROW services:

- PT 31 – Psychologist
- PT 35 – Physical Therapist
- PT 37 – Occupational Therapist
- PT 39 – Speech Therapist
- PT 41 – Registered Dietician
- PT 73 – Social Worker
To:    Prospective Residential Options Waiver Providers

From:   Office for Citizens with Developmental Disabilities

RE:      Residential Options Waiver Provider Enrollment/Medicaid Certification

After you receive your letter confirming your enrollment in Louisiana Medicaid as a Residential Options Waiver provider, then you must complete documentation to be added to the Freedom of Choice list. The Medicaid Freedom of Choice Request Form is located on the LDH website at http://new.dhh.louisiana.gov/index.cfm/page/141

Waiver service providers are required to comply with all documentation requirements contained in:
   1. The provider manuals.
   2. The information located on the LDH/OCDD website at http://dhh.louisiana.gov/index.cfm/newsroom/detail/1564

For information and documents on ROW refer to:
http://dhh.louisiana.gov/index.cfm/page/1875
Substitute Family Care
CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as a Substitute Family Care provider:

<table>
<thead>
<tr>
<th>Completed</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td>1. Completed PE-50 Entity/Business Louisiana Medicaid Provider Enrollment Form.</td>
</tr>
<tr>
<td>*</td>
<td>2. Completed PE-50 Provider Agreement Addendum Form.</td>
</tr>
<tr>
<td>*</td>
<td>4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.</td>
</tr>
<tr>
<td>*</td>
<td>5. (If submitting claims electronically) Completed Provider’s Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form and Power of Attorney Form (if applicable).</td>
</tr>
<tr>
<td></td>
<td>6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited (deposit slips are not accepted).</td>
</tr>
<tr>
<td></td>
<td>7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (W-9 forms are not accepted).</td>
</tr>
<tr>
<td></td>
<td>8. Copy of Home and Community Based Services License issued by LDH Health Standards, listing the Substitute Family Care (SFC) module.</td>
</tr>
<tr>
<td></td>
<td>9. To report “Specialty” for this provider type on Section A of the PE-50, please use Code 84 (Substitute Family Care).</td>
</tr>
</tbody>
</table>

For ROW Services:

| **       | 1. Completed Link/Unlink and Working Relationship Form. |
| **       | 2. Provider Verification Form for ROW Services. |
| **       | 3. To report “Sub-specialty” for this provider type on Section A of the PE-50 please use Code 4W (ROW). |

* These forms are available in the Basic Enrollment Packet for Individuals.

** Forms are included here.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT.

ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS).

Please submit all required documentation to:
Molina Medicaid Solutions Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
Louisiana Medicaid
Link/Unlink and Working Relationship Form

**PURPOSE**
This form is used when an individual provider (Therapist) is requesting to be linked to a Substitute Family Care provider. The form permits Linkage/Unlinkage to two separate Substitute Family Care providers. The form serves as documentation that a working relationship exists between an individual and Substitute Family Care provider. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE ARE REQUIRED.**

<table>
<thead>
<tr>
<th>Individual Provider Name:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Provider Number:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Group Name:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Group Provider Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LINK</td>
<td>Effective Date:</td>
<td>UNLINK Termination Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Group Name:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Group Provider Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LINK</td>
<td>Effective Date:</td>
<td>UNLINK Termination Date:</td>
</tr>
</tbody>
</table>

Contact Person for questions regarding this form:

Contact Person Phone Number: ( ) -

**WORKING RELATIONSHIP AGREEMENT**
I am a licensed individual who has a contractual agreement to see patients for the above named Substitute Family Care provider(s).
I understand that upon request I must provide LDH a copy of the written contractual agreement.

Print Individual Provider’s Name  Individual Provider’s Signature  Date

Original signature only – colored ink (please don’t use black ink)
Provider Verification for ROW Services

PURPOSE
This form confirms that the licensed individual specified below wishes to provide ROW Services to Louisiana Medicaid recipients and attests I have provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as a Dietician, Occupational Therapist, Physical Therapist, Psychologist, Speech Therapist, or Social Worker.

<table>
<thead>
<tr>
<th>Individual Provider Number:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Category (choose one):</th>
<th>Dietician</th>
<th>OT</th>
<th>PT</th>
<th>PSY</th>
<th>ST</th>
<th>SW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person for questions regarding this form:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person Phone Number: ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:
- True and correct, and
- that I can receive reimbursement for services provided only to those persons within the Residential Options Waiver (ROW), and
- that all Services I will provide to ROW participants must be prior authorized before services are rendered, and
- that as a licensed individual providing services to ROW participants, I have one year paid experience working with people with developmental disabilities as outlined in the ROW Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of ________________, State of ________________, on the __ day of ________________, 20__.

Print Individual Provider’s Name

Notary Public Signature

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety and mail the original to:
Molina Medicaid Solutions Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159