



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST
(Louisiana Medicaid Program)**

**INTERMEDIATE CARE FACILITY/
DEVELOPMENTALLY DISABLED
(ICF/DD) - GROUP HOME**

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE ICF/DD – GROUP HOME 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 additional three-week turnaround period.

ICF/DD – Group Home Provider Type 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 an ICF/DD – Group Home provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	<p>4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. (Only the Disclosure of Ownership portion of this enrollment packet can be done online by choosing Option 1.)</p> <p>Option 1 (preferred): Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.</p> <p style="text-align: center;">-or-</p> <p>Option 2 (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.</p>
<input type="checkbox"/> *	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).
<input type="checkbox"/>	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) .
<input type="checkbox"/>	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) .
<input type="checkbox"/>	8. Copy of Group Home license issued by Health Standards.
<input type="checkbox"/> **	9. Completed Provider Agreement.
<input type="checkbox"/>	10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 86 (Hospitals and Nursing Homes).

* These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

** Forms 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

Provider Agreement

BETWEEN INTERMEDIATE CARE FACILITY FOR THE HANDICAPPED AND LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

_____, hereinafter referred to as the facility, represented by _____, owner or legal agent, and _____, Administrator, and the Louisiana Department of Health and Hospitals (hereinafter referred to as DHH), hereby enter into the following agreement with respect to the provision of intermediate care services in an institution for individuals with developmental disabilities and payment therefore under the Title XIX Medical Assistance Program.

The facility agrees:

- 1 That the primary purpose of the institution (or distinct segment thereof) is the provision of habilitation services to individuals who have developmental disabilities and who are admitted in accordance with the facility's admission policies
- 2 That it shall be certified by the Division of Licensing and Certification as meeting health and safety standards contained in 42 CFR 442 400 through 442 516 which pertain to residential treatment facilities for individuals with developmental disabilities
- 3 That all residents referred for payment for intermediate care services require and are receiving active treatment as substantiated by initial medical, social, and psychological evaluations (and psychiatric evaluations as appropriate) and periodic re-evaluation
- 4 When a Medical Assistance recipient applies for admission to the facility to immediately submit a Form 148, Title XIX Long Term Care Facility Notification of Admission or Change, to the parish Office of Family Support
- 5 To notify the Division of Licensing and Certification and the Office of the Secretary (long Term Care Unit) in writing of a request for a change in facility classification, and to notify these offices two weeks in advance of change in administrators or other changes which would affect this agreement
- 6 To allow each recipient free choice of physician and pharmacy when these services are not provided by the facility within the Title XIX rate
- 7 To chart all medications provided to the recipient
- 8 To enter all medications for Medical Assistance recipients on the Physician's observation and orders form in the recipient's chart. If an order for medication is received orally, a responsible person shall enter and initial the verbal order for medication on the recipient's observation and orders form. All orders for medication shall be signed by the physician within forty-eight hours and his signature dated
- 9 To maintain adequate records which fully itemize all charges made to a recipient or third party and to make these records available for review immediately when requested by the Agency
- 10 Not to require that any part of the personal funds received by the recipient be paid as part of the facility fee. And not to require that any part of the recipient's income established by the Agency as needed for personal care be paid for the facility services
- 11 Not to solicit or accept funds to apply toward the charge for care and services of individual recipients from relatives, friends or charitable groups for payment in excess of the maximum participation rate for the facility
- 12 Not to require that a recipient have a sitter or bill the family for such services
- 13 To maintain, for those recipients desiring to keep personal funds on deposit at the facility, a personal account, with itemization of all deposits and disbursement, and to make the itemized account available to the Agency, the recipient, or a responsible relative upon request; and upon change of ownership of the facility, to provide to the new owner an itemized statement of each recipient's personal funds, such statement to be signed by the old and new owners

Provider Name _____

- 14 Not to require, expect or accept gratuities or anything else of monetary value for services by facility employees
- 15 To immediately notify the recipient's relatives and the Parish Office of Family Support in an emergency or at any time a Medical Assistance recipient becomes physically or mentally incapable of handling his own affairs
- 16 To promptly, within twenty-four hours, notify the Parish Office of Family Support in writing when a recipient dies or is discharged from the facility
- 17 To certify to the receipt of prescribed medications by signing or requiring that an authorized representative sign the drug billing form
- 18 To immediately notify the Parish Office of Family Support when the recipient requests to see his worker
- 19 To provide privacy for visits between the recipient and his worker, physician, clergyman, relatives and friends
- 20 To deliver unopened all correspondence directed to a recipient and to mail without censorship all correspondence originating with the recipient
- 21 To refund to the individual or his family, upon the recipient's discharge or death, the balance in his personal account and that portion of any advance payment not applied directly to the facility fee used by the patient
- 22 To make arrangements that will enable a responsible relative to visit a critically ill recipient when the relative's working hours make it impossible to visit during normal visiting hours established by the facility
- 23 To maintain and keep such records as required by the Agency and to have them available for inspection for five years from the date of services
- 24 To operate the intermediate care facility in accordance with the Civil Rights Act of 1964. This means that individuals are accepted and cared for and that all services and facilities (waiting rooms, toilets, dining rooms, recreation rooms, and room accommodations) are available to persons without regard to race, color, or national origin. Also, public facilities are available to visitors without regard to race, color, or national origin
- 25 To submit a quarterly report on personnel to the Licensing and Certification Division, and to notify appropriate personnel in that Division, when there is a change in number of personnel in any classification or any other change that may affect the licensing or certification status of the facility
- 26 Not to transfer a recipient elsewhere for continued care when the Agency will be expected to provide medical assistance unless the plan for such transfer has been jointly planned with the Parish Office of Family Support and the Long Term Care Unit
- 27 To provide the level of care and services to recipients certified to be in need of such care

DHH agrees to make payment to the facility on behalf of eligible residents according to its certification as a provider of intermediate care facility services. The facility will be paid on an individual, prospectively determined rate. In no case will payment be made for intermediate care services to a facility for a period of non-compliance.

Effective date of this agreement shall be _____ through _____, or until further Extended. This agreement covers _____ beds.

Print the Name of the Authorized Representative

Title / Position of Authorized Representative

Signature of Authorized Representative

Date of Signature