PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Substitute Family Care

(Enrollment packet is subject to change without notice)

PT 84
Revised 6/2021

GENERAL INFORMATION

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.

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

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

ATTENTION!!

Waiver service providers are required to comply with all requirements contained in:

1. The provider manuals located at:

https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

And

2. The information located on the LDH/OCDD website at

http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8

Substitute Family Care

CHECKLIST OF FORMS TO BE SUBMITTED

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

Completed	Document Name
☐ *	1.Completed PE-50 Entity/Business Louisiana Medicaid Provider Enrollment Form.
*	2.Completed PE-50 Provider Agreement Addendum Form.
*	3.Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
*	4.Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
*	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).
	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).
	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).
	8. Copy of Home and Community Based Services License issued by LDH Health Standards, listing the Substitute Family Care (SFC) module.
	9.To report "Specialty" for this provider type on Section A of the PE-50, please use Code 84 (Substitute Family Care).

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:
Gainwell 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.

Individual Provider Name:				
Individual Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)	
Professional Group Name:				
Professional Group Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)	
☐ LINK	Effective Date:		☐ UNLINK	Termination Date:
Professional Group Name:				
Professional Group Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)	
☐ LINK	Effective Date:		☐ UNLINK	Termination Date:
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.

Individual Provider Number:	LA Medicaid Provider # (leave blank if new applicant)	National Provider Identifier (NPI)
Individual Provider Name:		
Physical Address:		
Professional Category (choose one):	Dietician ☐ OT ☐ PT ☐ PSY ☐ ST ☐ SW ☐	
Contact Person for questions regarding this form:		
Contact Person Phone Number:	( ) -	

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)

Individual Provider's Signature

Original signature only – colored ink (please don't use black ink)

Complete this form in its entirety and mail the original to:

Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159