ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid)

Home Delivered Meals

(Enrollment packet is subject to change without notice)

(PT AM)
Revised 11/20

GENERAL INFORMATION FOR PROVIDER ENROLLMENT

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.

All providers will automatically be added to the Freedom of Choice list upon completion of the enrollment process.

NOTICE TO WAIVER SERVICE PROVIDERS

Please note that Louisiana Medicaid will only reimburse you for waiver services rendered to Medicaid recipients who are enrolled in a waiver program (New Opportunities Waiver (NOW), Children's Choice Waiver, Supports Waiver, Residential Options Waiver (ROW), Adult Day Health Care (ADHC) Waiver and Community Choices Waiver). Medicaid will not reimburse you for waiver services provided to recipients who are not enrolled in one of the waiver programs.

NOTICE TO HOME DELIVERED MEALS PROVIDERS:

In-State Providers must meet current state standards for providers of home delivered meals as specified in the Louisiana Administrative Code Title 51 Public Health Sanitary Code Part XXIII, or sub-contract with entities who meet these requirements.
Out-of-State Providers must meet current federal standards for providers of home delivered meals as specified in Code of Federal Regulations (CFR) Title 9 Section 300 et seq.

ATTENTION!!

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

1. **The provider manuals located at** http://www.lamedicaid.com

   And

2. **The information located on the DHH/OAAS website at** http://new.dhh.louisiana.gov/index.cfm/subhome/12/n/7

Home Delivered Meals

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 Home Delivered Meals provider:

Completed	Document Name
☐ *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
☐ *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. **(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)** **Option 1**: 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. **-or-** **Option 2**: 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.
☐ *	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. Completed and notarized "Provider Attestation for OAAS Community Choices Waiver Home Delivered Meals" Form.
☐	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 8M (Home Delivered Meals).
☐	10. If Home Delivered Meal services are to be rendered by a Subcontractor, skip to numbers 17 thru 20 below. If no Subcontractor will be used, proceed to numbers 11 thru 16 below.

FOR PROVIDERS IN LOUISIANA:

☐	11. Copy of Retail Food Establishment permit/license for operating a Retail Food Establishment issued by the LA Department of Health and Hospitals, Office of Public Health Retail Food Program.
☐	12. Copy of inspection certificates for retail food preparation, processing, packaging, storage and distribution issued by the local Health Department (of LA Department of Health and Hospitals, Office of Public Health Retail Food Program).
☐	13. Copy of Food Safety Certificate issued by the LA Department of Health and Hospitals, Office of Public Health Retail Food Program.

-OR - FOR PROVIDERS OUTSIDE OF LOUISIANA:

☐	14. Copy of "*USDA Food Safety and Inspection Service Grant of Inspection"* certificate.
☐	15. Copy of All Permits and Licenses for food preparation, processing, packaging, storage and distribution issued by the state of operation.

If Using a SUBCONTRACTOR:
Both the Provider and the Subcontractor Must Be Located in Louisiana:

☐**	16. Submit the Subcontractor Information Form for PT-AM (Home Delivered Meals).
☐	17. Copy of Retail Food Establishment permit/license for operating a Retail Food Establishment issued by the LA Department of Health and Hospitals, Office of Public Health Retail Food Program in the name of the Subcontractor.
☐	18. Copy of inspection certificates for retail food preparation, processing, packaging, storage and distribution issued by the local Health Department (of LA Department of Health and Hospitals, Office of Public Health Retail Food Program) in the name of the Subcontractor.
☐	19. Copy of Food Safety Certificate issued by the LA Department of Health and Hospitals, Office of Public Health Retail Food Program in the name of the Subcontractor.

*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:
Gainwell Provider Enrollment Unit P.O. Box 80159
Baton Rouge, LA 70898-0159

Provider Attestation for Community Choices Waiver
Home Delivered Meals

PURPOSE

This form confirms that the provider specified below wishes to provide services under the Community Choices Waiver program, and attests that the provider will conform to prior approval and reimbursement regulations and policies.

Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)		**National Provider Identifier (NPI)**
Provider Name:			
Physical Address:			
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 will comply with providing up to two nutritionally balanced meals per day that may be delivered to the home of the eligible participant and that each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture.
- that I can receive reimbursement for services provided only to those persons within the Community Choices Waiver; and
- that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare; and
- that failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid; and
- that Home Delivered Meals services provided to Community Choices Waiver participants must be prior authorized before services are rendered; and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

_____	_____	_____
Print Authorized Representative's Name	Signature of Authorized Representative	Date of Signature

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

_____

Notary Public Signature

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety. Original signature required – blue ink only

(PT AM)
Revised 3/15

SUBCONTRACTOR INFORMATION FORM FOR
PT-AM (HOME DELIVERED MEALS)

NAME OF ENROLLING PROVIDER: _____

SUBCONTRACTOR NAME:	**PHONE:**
PHYSICAL ADDRESS:	**FAX:**
CITY, STATE, ZIP:	
MAILING ADDRESS:	
CITY, STATE, ZIP:	
EMAIL:	
CONTACT PERSON NAME AND TITLE:	
CONTACT PERSON PHONE:	

Check each box:

The enrolling provider:

☐ Attests that they have an active contract with the above named subcontractor.

☐ Assumes total responsibility for any and all aspects of this contract with regard to Medicaid payments and subcontractor manager/employee exclusions.

☐ Understands that they are responsible for the subcontractor's adherence to all Louisiana Medicaid Rules and Regulations.

Sign and date below:

_____
Print Name of Authorized Representative

_____
Title of Authorized Representative

_____ _____
Signature of Authorized Representative Date of Signature

Complete this form in its entirety. Original signature required – blue ink only