



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST**

(Louisiana Medicaid Program)

**Shared Living
(Entity/Business)**

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE SHARED LIVING 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.

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

A separate enrollment packet must be completed for each DHH Administrative Region in which your agency will be providing services as a Shared Living Residential Option Waiver (ROW) provider.

Any Shared Living provider applying for ROW services must send the enrollment application to the ROW Program Manager at the Office for Citizens with Developmental Disabilities. See Checklist on the next page for complete address.

The following individual Provider Types may be linked and reimbursed through the Shared Living provider type:

- 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 DHH website at

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=191&Detail=1217>

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

1. The provider manuals.
2. The information located on the DHH/OCDD website at

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=191>

For information and documents on ROW refer to:

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=191&Detail=1952>

SHARED LIVING

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 Shared Living 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 Supervised Independent Living (SIL) license issued by Health Standards.
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 4A (Developmental Disability).
<input type="checkbox"/>	10. To report "Subspecialty" for this provider type on Section A of the PE-50, please use 4G (New, Provider Domain), 4L (New, Participant Domain), 4J (Conversion, Provider Domain), and/or 4H (Conversion, Participant Domain).

* 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. FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS) – DO NOT SUBMIT COPIES OF THE ATTACHED FORMS.

Please submit all required documentation to:
Office for Citizens with Developmental Disabilities
ROW Program Manager
PO Box 3117
Baton Rouge, LA 70821-3117

Louisiana Medicaid Link/Unlink and Working Relationship Form

PURPOSE

This form is used when an individual provider is requesting to be linked to a Professional Group or Entity. The form permits Linkage/Unlinkage for two separate professional groups. When linking to a group, the estimated number of hours is required. The form also serves as documentation that a working relationship exists between an individual and a professional group. 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)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week, if linking. (required)													
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week, if linking. (required)													
Contact Person for questions regarding this form:													
Contact Person Phone Number:		() -											

WORKING RELATIONSHIP AGREEMENT

I am a medical professional who has a contractual agreement to see patients for the above named professional group(s) or entity. I have recorded the approximate number of hours to be worked at each group per week in the space(s) provided above. (I understand that upon request I must provide DHH 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)