PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Substitute Family Care

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION
REGARDING WAIVER ENROLLMENTS

- The effective date is the date of enrollment approval.

- Non active billing will result in deactivation of the Medicaid provider number. To be reinstated, a provider must meet all enrollment requirements.

- 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.

- An updated license must be obtained and submitted to Provider Enrollment for physical address changes.

- 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**

GENERAL POLICY INFORMATION:

Waiver service providers are required to comply with both policy and program requirements located on the Louisiana Department of Health (LDH) Office for Citizens with Developmental Disabilities (OCDD) website and the Louisiana Medicaid provider manuals linked below.

Louisiana Medicaid Provider Manuals located at:
https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

LDH/OCDD website: at
https://www.ldh.la.gov/OCDD

Please note Louisiana Medicaid will not reimburse you for waiver services provided to participants who are not enrolled in one of the waiver programs.

Substitute Family Care

REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

*Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

**Forms are included here.

Completed		Document Name
☐	*	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐	*	2. PE-50 Provider Agreement Addendum Forms (three pages).
☐	*	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐	*	4. Louisiana Medicaid Ownership Disclosure Information Forms.
☐	*	5. **(If submitting claims electronically)** 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. Copy of Child Placing Agency License. ** Required if providing services to children under 18 years of age. – LAC Title 67 Chapter 73
☐		10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 84 (Substitute Family Care).

For ROW Services:

☐	**	11. Link/Unlink and Working Relationship Form for linked professionals if applicable.
☐	**	12. Provider Verification form for ROW Services.
☐		13. To report "Sub-specialty" for this provider type on Section A of the PE-50 please use Code 4W (ROW).

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Louisiana Medicaid Link/Unlink and Working Relationship Form

Copy this form for additional space as needed.

PURPOSE

This form allows one individual to link to and/or unlink from two (2) separate entities/businesses.
This form also serves as documentation that a working relationship exists between an Individual and an Entity.

Individual Provider Name:			
Individual Provider Number	LA Medicaid Provider #	National Provider Identifier (NPI)	
Entity Name:			
Entity Provider Number	LA Medicaid Provider #	National Provider Identifier (NPI)	
LINK	Effective Date:	UNLINK	Termination Date:
Approximate Number of Hours Working at this Entity Per Week (required)			
Entity Name:			
Entity Provider Number	LA Medicaid Provider #	National Provider Identifier (NPI)	
LINK	Effective Date:	UNLINK	Termination Date:
Approximate Number of Hours Working at this Entity Per Week (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-identified entity(s). I recorded the approximate number of hours working per week for the entity(s) identified above.
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 of Signature**

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
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PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Provider Verification for ROW Services

PURPOSE

This form confirms that the individual specified below wishes to provide ROW Services to Louisiana Medicaid recipients, and attests that the individual has 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 Professional Services provided to ROW participants must be prior authorized before services are rendered, and
- that as a Professional 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

_____ Individual Provider's Signature

Notary Seal or Notary Identification Number (required)

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
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