PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED (ICF/DD)

(Enrollment packet is subject to change without notice.)

INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED (ICF/DD) Provider Type

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 Addendum – Provider Agreement Forms (three pages).
☐ *	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
☐ *	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 ICF/DD license issued by Health Standards.
☐ **	9. Provider Agreement Form (three pages).
☐	10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code **86 (Hospitals and Nursing Homes).**

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

Provider Number: _____

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 LDH), 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 beneficiary 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 beneficiary 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 beneficiary

8. To enter all medications for Medical Assistance beneficiaries on the Physician's observation and orders form in the beneficiary's chart. If an order for medication is received orally, a responsible person shall enter and initial the verbal order for medication on the beneficiary'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 beneficiary 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 beneficiary be paid as part of the facility fee. And not to require that any part of the beneficiary'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 beneficiaries from relatives, friends or charitable groups for payment in excess of the maximum participation rate for the facility

12. Not to require that a beneficiary have a sitter or bill the family for such services

13. To maintain, for those beneficiaries 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 beneficiary, 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 beneficiary's personal funds, such statement to be signed by the old and new owners

14. Not to require, expect or accept gratuities or anything else of monetary value for services by facility employees

15. To immediately notify the beneficiary's relatives and the Parish Office of Family Support in an emergency or at any time a Medical Assistance beneficiary 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 beneficiary 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 beneficiary requests to see his worker

19. To provide privacy for visits between the beneficiary and his worker, physician, clergyman, relatives, and friends

20. To deliver unopened all correspondence directed to a beneficiary and to mail without censorship all correspondence originating with the beneficiary

21. To refund to the individual or his family, upon the beneficiary'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 beneficiary 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 beneficiary 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 beneficiaries certified to be in need of such care

Provider Name: _____

LDH 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 Name of Authorized Representative | Title / Position of Authorized Representative

_____ _____

Signature of Authorized Representative | Date of Signature

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