PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Home Delivered Meals

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION
REGARDING WAIVER ENROLLMENT

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

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.

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 of Aging and Adult Services (OAAS) website and the Louisiana Medicaid provider manuals linked below.

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

LDH/OAAS website:
https://www.ldh.la.gov/OAAS

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

Home Delivered Meals
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.
☐ *	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. 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 Meals 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, 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 (LA Department of Health, Office of Public Health Retail Food Program).
☐	13. Copy of Food Safety Certificate issued by the LA Department of Health, Office of Public Health Retail Food Program.

-OR- 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 Subcontractor MUST be Located in Louisiana)

☐ **	16. 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, 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 (LA Department of Health, 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, Office of Public Health Retail Food Program in the name of the Subcontractor.

FOR PROVIDERS PROVIDING MEDICALLY TAILORED MEALS AND NUTRITIONAL COUNSELING:

☐	20. To report "Subspecialty Code" for this provider type on Section A of the PE-50, please use Code 6V (Medically Tailored Meals).
☐ **	21. Notarized "Provider Attestation for OAAS Community Choices Waiver Medically Tailored Meals/Nutritional Counseling" form.

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 Attestation for OAAS Community Choices Waiver
Home Delivered Meals

PURPOSE

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

Provider Number:	**LA Medicaid Provider Number:**		**National Provider Identifier (NPI):**
	(leave blank if new applicant)		
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;
- That I will comply with providing up to two (2) 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;
- That Medicaid Community Choices Waiver (CCW) 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;
- 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;
- That Home Delivered Meals services provided to Community Choices Waiver participants must be prior authorized before services are rendered;
- 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

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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 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

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 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 Attestation for OAAS Community Choices Waiver
Medically Tailored Meals/Nutritional Counseling

PURPOSE

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

Provider Number:	**LA Medicaid Provider Number:**		**National Provider Identifier (NPI):**
	(leave blank if new applicant)		
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;
- That I will comply with providing up to two (2) Medically Tailored Meals a day, which are nutritionally balanced meals approved by a Dietitian provided 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;
- All meals will be developed under the supervision of a Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN)/Licensed Dietitian Nutritionist (LDN) and comply with the current Dietary Guidelines for Americans as published by the United States Department of Health and Human Services (HHS) and the United States Department of Agriculture (USDA), meet the current recommended dietary allowance (RDA)/dietary reference intakes (DRI) established by the Food and Nutrition Board of Institute of Medicine of the National Academy of Sciences and follow current standards for specific diseases or conditions. This service does not constitute a full nutritional regimen;
- The Nutritional Counseling service will be provided by an RD/RDN/LDN who is credentialed and in good standing with the Commission on Dietetics Registration;
- That I will employ or subcontract with nutritional counselor(s) licensed to practice in the State of Louisiana by the Louisiana Board of Examiners in Dietetics and Nutrition;
- That Medically Tailored Meals and Nutritional Counseling services provided to Community Choices Waiver participants must be prior authorized before services are rendered;
- That I can receive reimbursement for services provided only to those persons within the Community Choices Waiver;
- 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;
- 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
- 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 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