

CHAPTER 7: COMMUNITY CHOICES WAIVER**APPENDIX B: FORMS****PAGE(S) 4****APPENDIX B**

The following forms, handbooks, and procedural policies are available on the Office of Aging and Adult Services' website:

Form/Document Name	Web Address
Back-Up Staffing Plan	http://new.dhh.louisiana.gov/assets/docs/OAAS/EmergencyPrep/BackupStaffingPlanForm.pdf
Emergency Plan	http://new.dhh.louisiana.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf
Rights and Responsibilities for Applicants/Participants of Home and Community-Based Waiver Services (HCBWS)	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf
Log of Weekly Services/Supports and Daily Progress Notes for Community Choices Waiver – PAS – Single Employee	http://www.dhh.la.gov/assets/docs/OAAS/publications/CWFactSheet/OAAS_CCW-PASServiceFill-Save.pdf
OAAS Transition Services Expense and Planning Approval (TSEPA) Form	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/OAASPF07010TSEPAFormRI81408.pdf
<i>OAAS Critical Incident Reporting Policies and Procedures</i>	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/OAASADM10020CIRpoliciesOAASRI62210HENLEYLEVELLE.pdf
<i>Louisiana Department of Health and Hospitals Office of Aging and Adult Services Self-Direction Option Community Choices Waiver Employer Handbook</i>	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/CommChoice/SELFDIRECTIONSEmployerHandbook.pdf
<i>Louisiana Department of Health and Hospitals Office of Aging and Adult Services Permanent Supportive Housing Policies and Procedure Manual</i>	http://new.dhh.louisiana.gov/assets/docs/OAAS/PSH/PSHManual.pdf
Community Choices Waiver Permanent Supportive Housing Housing Stabilization Services Housing Transition/Crisis Intervention Services Progress Note Form	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/PSHProgressNote.pdf

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The following form and instructions are included on the following pages:

Form Name
Request for Payment/Override Form

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Reissued October 17, 2011 Replaces All Previous Issuances	REQUEST FOR PAYMENT/OVERRIDE FORM	OAAS-PF-08-014 Page 1 of 2
<i>This form will be used for:</i>		
Request for Payment of Transition Intensive Support Coordination	Request for payment of Transition Services	Request for Payment of Denied Claims
Participant Name: _____ Medicaid # (13 digits): _____ Date of Birth: _____		
Agency Name: _____ Agency Contact Person: _____ Agency Phone: _____		
Agency Fax Number: _____ Agency E-mail Address: _____		
Population: Check One _____ COMMUNITY CHOICES _____ ADHC _____ Other _____		
Reason for Request: _____		
PA Request is for: Begin Date: ____/____/____ End Date: ____/____/____ Initials Only: Date Support Coordination Agency Received the 18-W: ____/____/____		
ATTACH ONLY THOSE DOCUMENTS NECESSARY TO JUSTIFY REQUEST: (DHH may request additional information.) Check documents that are attached.		
Approved CPOC _____ Progress Notes/Typed Chronology _____ CMS 1500 (completed) _____ Other: _____		
DHH WILL NOT OVERRIDE TIMELY FILING LIMITS. IT IS THE RESPONSIBILITY OF EACH AGENCY TO RECONCILE ALL BILLINGS IN A TIMELY MANNER. DHH WILL REQUIRE A MAXIMUM OF FORTY-FIVE (45) CALENDAR DAYS TO PROCESS ALL REQUESTS AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION. ANY REQUEST NOT CONTAINING THE NECESSARY INFORMATION WILL BE RETURNED AS INCOMPLETE AND CONSIDERED NOT RECEIVED.		
TO BE COMPLETED BY OAAS:		
Notes: _____ APPROVED _____ DENIED _____ RETURNED (See Reason Below)		
If Denied or returned, please provide reason below:		
OAAS Authorized Reviewer _____ Date _____		
TO BE COMPLETED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) IF APPLICABLE:		
Notes: _____ APPROVED _____ DENIED _____ RETURNED (See Reason Below)		
If Denied or returned, please provide reason below:		
DHH/WAC Authorized Reviewer _____ Date _____		

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INSTRUCTIONS FOR COMPLETING REQUEST FOR PAYMENT/OVERRIDE FORM	
<p style="text-align: center;">Step One - Indicate Reason for Use of Form.</p> <p>1.) <u>Request for Payment of Transition Intensive Support Coordination (TISC)</u> – Use form to request payment for TISC services for up to four months prior to the individual transitioning out of a nursing facility.</p> <p>2.) <u>Request for Payment of Transition Services</u> – Use form to request payment of funds expended by a designated purchaser prior to learning a participant will be unable to transition back into the community with a waiver opportunity...</p> <p>3.) <u>Request for Payment of Denied Claims</u> – Use form to request payment of claims denied by UNISYS.</p>	
<p style="text-align: center;">Step Two - Complete Demographic and Support Coordination Agency Information</p> <p>Do not leave any blanks. Indicate the waiver or targeted case management population the request is for.</p> <p style="text-align: center;">Step Three - Reason for Request:</p> <p>Be specific. For "Request for Payment of Denied Claims", indicate the reason for the request and include the 3 digit Medicaid claim denial code from the Remittance Advice, i.e., observation services could not be completed because services did not begin until after the quarter. Indicate what services did not begin in that quarter and the date the services did begin (this is needed so the PA for the provider can be canceled for that period). Denial Code 191</p>	
<p style="text-align: center;">Step Four - PA Request is for:</p> <p>Indicate the start and end date for the period of reimbursement you are requesting.</p> <p style="text-align: center;">Step Five - Date Support Coordination Agency Received the 18-W:</p> <p>Indicate the date the support coordination agency received the 18-W</p>	
<p style="text-align: center;">Step Six - Support Documents Required:</p> <p>Based on documentation provided, DHH will review and either approve, deny, or return the request.</p> <p>Attach only those documents necessary to justify your request; i.e.</p> <p>Request for Payment Reason 1.) Approved POC, progress notes, CMS 1500 (completed), and any other pertinent documents necessary.</p> <p>Request for Payment Reason 2.) Copy of <u>Pre-approved Transition Services Expense Planning and Approval (TSEPA)</u> form, copy of revised POC budget sheet, copies of all receipts for expenditures from designated purchaser, copies of canceled checks, and narrative explaining why transition did not take place.</p> <p>Request for Payment Reason 3.) If observation of services could not be completed submit program notes or typed chronology that supports request for payment. If denial is for late CPOC due to issues with requesting additional information, attach any correspondence received relative to the delay. PROGRESS NOTES MUST BE LEGIBLE.</p>	
<p style="text-align: center;">Step Seven - First Signature Block</p> <p>To be completed by OAAS Regional Office (R.O.) - Support coordinator agency will submit completed form and supporting documentation to OAAS R.O. for approval and signature. If denied or returned, the OAAS R.O. will give a detailed explanation for rejection, using an extra sheet if necessary. If approved, OAAS R.O. will e-mail a copy to the support coordination agency, a copy to SRI.ljarrett@statres.com for payment, and a copy to susan.robinson@la.gov at OAAS State Office (S.O.).</p>	
<p style="text-align: center;">Step Eight - Second Signature Block</p> <p style="text-align: center;">TO BE USED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) SECTION, WHEN APPLICABLE.</p>	
<p>Reissued October 17, 2011 Replaces All Previous Issuance</p>	<p>OAAS-PF-08-014 Page 2 of 2</p>