

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
December 13, 2012
MB# 12-060

MEDICAID BULLETIN

Phys
Hosp
Med Clin
NF
HH

TO: Providers Indicated

SUBJECT: Referrals to Community Long Term Care (CLTC)

Effective January 7, 2013, the Division of Community Long Term Care (CLTC) will centralize intake activities for all programs operated by CLTC. This includes referrals for nursing home placement, nursing home conversion, Pre-Admission Screening Resident Review (PASRR), home and community based waiver services, children's personal care and nursing services, and Katie Beckett Medicaid Program (TEFRA). When intake activities are centralized, referrals will no longer be accepted at the CLTC Regional Offices. Referrals will only be accepted by one of the methods below.

Telephone

855-278-1637

Fax

803-255-8209

Mail

South Carolina DHHS
Community Long Term Care Intake – J7
P. O. Box 8206
Columbia, SC 29202-8206

The toll free number will not be available until January 7, 2013. To make a written referral, the attached application will need to be completed and submitted. No other written documentation will be needed except the completed PASRR for PASRR referrals. If you would like an electronic copy of the application form or have questions concerning this change, please contact Rhonda Feaster at feaster@scdhhs.gov or 803-898-2532.

Thank you for your continued participation in the South Carolina Medicaid program.

/s/
Anthony E. Keck
Director

Attachment

Fraud & Abuse Hotline 1-888-364-3224

Community Long Term Care Application For Services

REASON FOR REFERRAL

(Circle appropriate program)

- | | | |
|---|------------------------------------|------------------------------|
| 1. Pre-Admission Review | 5. HIV/AIDS Waiver | 10. TEFRA |
| 2. Nursing Home Conversion
Date: _____ | 6. Ventilator Waiver | 11. Money Follows The Person |
| 3. Non Medicaid PASRR | 7. Children's Personal Care | 12. PACE |
| 4. Community Choices Waiver | 8. Children's Private Duty Nursing | |
| | 9. Medically Complex Children | |

APPLICANT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Suffix _____
 Permanent Address _____
 City _____ State _____ Zip Code _____
 County _____ Phone Number _____
 Social Security Number _____ Medicare Number _____
 Medicaid Number _____ Date of Birth _____

DEMOGRAPHIC DATA

(Circle Appropriate Categories)

GENDER	MARITAL STATUS	RACE	EDUCATION LEVEL	PRIMARY LANGUAGE
Female	1. Married	1. White	1. Less than third grade	Is primary language English?
Male	2. Widowed	2. Black	2. Third through eighth grade	Yes or No
	3. Divorced/Separated	3. Asian	3. Some High School	If no, specify language
	4. Single	4. Hispanic	4. High School Graduate	_____
		5. Indian	5. Some College	
		6. Other	6. College Graduate	

PRESENT LOCATION

Name of Facility _____ Address _____
 City _____ State _____ Zip Code _____

CONTACT PERSON

Name _____ Address _____
 City _____ State _____ Zip Code _____
 Home Phone Number _____ Alternate Phone Number _____
 Is primary language English? Yes or No If no, specify language: _____

Relationship to applicant

- | | | |
|-------------------------|----------------|-----------------|
| 1. Spouse | 5. Aunt/Uncle | 9. Niece/Nephew |
| 2. Child/Child's Spouse | 6. Cousin | 10. Friend |
| 3. Sibling | 7. Grandparent | 11. Neighbor |
| 4. Parent | 8. Grandchild | 12. Self |
| | | 13. Other |

Reason for referral (circle functional dependencies)

Locomotion Transfer Bathing Dressing Toileting Eating Incontinence Confusion Cognitive Impairment

HIV Referral Only Diagnoses with HIV or AIDS? Yes or No

Ventilator Waiver Only Uses ventilator at least 6 hours daily? Yes or No

Children's Personal Care or Private Duty Nursing Current Medicaid Recipient? Yes or No Needs personal care or nursing service? Yes or No

Does applicant know a referral is being made? Yes or No

If not, why not? _____

REFERRAL SOURCE

- | | | |
|---------------------|----------------------|----------------------|
| 1. DSS | 6. Hospital | 11. Family/Friend |
| 2. DHEC | 7. Nursing Home | 12. Home Health |
| 3. DMH | 8. Physician | 13. Community RCF |
| 4. DDSN | 9. CLTC | 14. HMO |
| 5. Council on Aging | 10. HIV Organization | 15. Self |
| | | 16. DHHS/Eligibility |
| | | 17. ADRC |
| | | 18. Hospice |
| | | 19. Waiver Provider |
| | | 20. Dialysis Center |

Name of Referral Source _____ Agency/Institution _____
 Phone Number _____ Address _____
 City _____ State _____ Zip Code _____
 Signature _____ Date _____

(For CLTC Use Only)

Application Date _____ Program Assistant _____