

State of Delaware



The Department of Services for Children, Youth and Their Families (DSCYF)
Division of Management Support Services – Cost Recovery Unit (CRU)

Cost Recovery Documentation

Dear Colleague:

Under an agreement between DSCYF and Delaware Medicaid, DSCYF is the exclusive provider of Medicaid behavioral health and substance abuse services to children in Delaware.

In order for DSCYF's Cost Recovery Unit to pursue Medicaid reimbursement for services we provide to Delaware children through a third party such as your organization, we must obtain certain documentation from you annually. In your Contract or Statement of Agreement (Article I, Section B.5) with DSCYF you agree to provide this information.

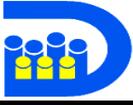
We are requesting the following:

1. **Required: 3 GREEN FORMS** – These are standard forms that we require all of our providers to complete and sign annually (*including mental health subcontractors*).
 - **Rate Cert Form NR** - Please provide the “**usual and customary rate**” that you charge to the general public for the services you have contracted with DSCYF. These rates *may be different* from the DSCYF Contracted Rates. Per Federal Regulations, DSCYF can only receive Medicaid reimbursements at or below the **usual and customary rate** that is charged to the general public. (*42 CFR 447.271 - Upper Limits Based on Customary Charges*)
NOTE: If you have rate information already prepared and do not want to handwrite your rates on this form, please attach your rate information to the **signed** Rate Certification Form.
 - **CMS Sanctions Form**
 - **Accreditation Status Form**
2. **Required: Copies of Licenses, Certificates, Accreditations, and NPI Letter**
 - **Professional Licenses:** If you are a clinician in private practice, please send a copy of your current professional license.
 - **Facility Licenses:** Different states use different wording for each type of license. Examples of facility licenses and/or certificates we need include, but are not limited to: Alcohol & Drug, Child & Youth Agency, Child Caring Institution, Child Placing Agency, Day Treatment, Foster Care, Group Home, Hospital, Outdoor program, Private Child & Youth Agency, Psychiatric Hospital, Residential Services, Residential Treatment, and Residential Childcare.
 - **Accreditations:** Please send a copy of any accreditation you may have. For JCAHO accreditation, send a copy of the JCAHO certificate and a copy of the JCAHO letter that specifies the effective month, day and year of the accreditation.
 - **NPI Letter:** Please send a copy of your NPI assignment letter or NPI assignment email.
3. **Other Information:**
 - Any additional program or rate information that will help us in our Medicaid recovery efforts would be greatly appreciated.
 - Please return the completed, signed, GREEN FORMS (originals), copies of licenses and certificates, and any other information with your signed contract.

Or, you can mail them directly to:

State of Delaware
DSCYF - DMSS
Cost Recovery Unit
1825 Faulkland Road
Wilmington, DE 19805
Attn: Charlotte Martin, MA II

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If you expect a delay of more than two weeks in your response, or if you have any questions, please contact me.

The funds we recover from Medicaid allow us to provide more services, through you, to the children of Delaware.

Thank you for your cooperation.

Sincerely yours,

Charlotte Martin, Management Analyst II
DSCYF-DMSS
Cost Recovery Unit
Phone: 302-892-4567
Fax: 302-661-7224
E-mail: charlotte.martin@state.de.us

Enclosures: 3

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Complete a separate form for each location for which services are contracted by DSCYF.
If a service is program funded, not per diem, please check Yes for “**Program Funded**” and skip Sections I and II.
Otherwise please list both your “usual and customary rate” and the DSCYF contracted rate for all services.
If you operate an education program as part of the treatment program, please show the education cost as a separate rate. If children in the program attend public school, it is not necessary to list the public education cost.

Contracting Division	
Contract ID (found on your DSCYF Contract)	
Contract Period	
Program Funded	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section I

Service Type	Procedure Code and Modifier	Procedure Description	Contracted DSCYF Rate	Academic/Special Education, etc. Rate	Usual and Customary Rate

Section II

Is your facility enrolled with Medicaid?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, which States?	

Section III

Agency Name	
Name of Authorized Representative	
Title of Authorized Representative	
Signature of Authorized Representative	
Date	
Phone	
E-mail	

Please complete, sign, and return this form to charlotte.martin@state.de.us, fax 302.661.7224, phone 302.892.4567 or mail to: DSCYF/DMSS/CRU, 1825 Faulkland Rd., Wilmington, DE 19805

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CMS SANCTIONS CERTIFICATION FORM

Per the SOCIAL SECURITY ACT, SEC. 1128, 42 USC Sec. 1320a-7 “Exclusion of certain individuals and entities from participation in Medicare and State health care programs,” the Secretary of U.S. Department of Health and Human Services may exclude individuals and entities from participation in any Federal health care program, including Medicaid and Medicare, or any State health care program.

I, the undersigned, as an authorized representative of this agency, certify that this agency has never been sanctioned by the Centers for Medicare & Medicaid Services (CMS), formerly HCFA, or had a license revoked.

Date

Authorized Signature

Printed Name

Title

Agency

Street Address

City, State, Zip

Phone Number

Email address

If your agency has ever been sanctioned, please provide details including date of reinstatement.

SEND ORIGINAL (NOT PHOTOCOPIED) SIGNATURE ONLY.

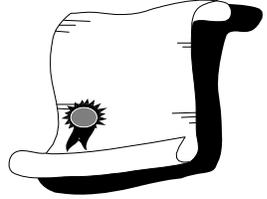
Return with contract or mail to: Cost Recovery Unit/DMSS/DSCYF
1825 Faulkland Road, BMP 2120
Wilmington, DE 19805
302-892-4567 or 302-892- 4565

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ACCREDITATION STATUS FORM



- Checkboxes for accreditation status: This organization is not accredited. This organization is accredited.

Accrediting Organization(s) From: Period of Accreditation To: mm/dd/yy

Please detail which parts of your organization are covered by the accreditation standards (If your entire organization is accredited, it is only necessary to indicate "All" instead of providing a comprehensive list). In addition, please specify facility or campus names included in the survey (if applicable) within each service area.

Large empty rectangular box for detailing accreditation coverage.

PLEASE PROVIDE A COPY OF THE ACCREDITATION CERTIFICATE FOR OUR FILE

Date

Name of person completing form (please print)

Phone number

Agency

Email address