Residential Form Packet

Dear Service Provider:

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 reimbursement from Medicaid 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.

Please return the completed, signed forms, copies of licenses and certificates, the separately attached Disclosure Statement and any other information with your signed contract via email, fax, or mail:

You can email to:	charlotte.martin@state.de.us
Or, You can fax to: *(Must use all 10 digits)*	302.661.7224
Or, You can mail to	STATE OF DELAWARE DSCYF-DMSS-N301 COST RECOVERY UNIT (ATTN: CHARLOTTE MARTIN) 1825 FAULKLAND ROAD, WILMINGTON, DE 19805

We are requesting the following:

1. **Required: FORMS** – These are standard forms that we require all of our providers to complete and sign annually ***(including mental health subcontractors)***.
   - **Rate Certification Form** - 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 Certification Form**
   - **Accreditation Status Form**
   - **Disclosure of Ownership and Control Interest Statement (separate attachment)**
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.
   - **State Medicaid Letter**: Please provide a copy of your State's Medicaid agency letter showing your Medicaid enrollment and rate(s).
3. **Other Information**:
   - Any additional program or rate information that will help us in our Medicaid recovery efforts would be greatly appreciated.

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,

Charlotte Martin, Management Analyst II
DSCYF-DMSS-N301
Cost Recovery Unit
Phone: 302.892.4567 | Fax: 302.661.7224 | E-mail: charlotte.martin@state.de.us

Enclosures: 3

RATE CERTIFICATION FORM - Residential

Usual and Customary Charges to the General Public

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.**" 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.

Contract ID # (found on your DSCYF Contract)		
Contract Period	**From:**	**To:**
Program Funded	☐ YES ☐ NO	
Do children in your residential program receive public education through a State's public school system?	☐ YES ☐ NO	
Where is the education provided?	☐ On-Site ☐ Off-Site	

Facility / Program Name	Service Description	Healthcare Procedure Billing Code	Contracted DSCYF Rate	Usual & Customary Education Rate	Usual & Customary Residential Rate	Usual & Customary Total Rate	Medicaid Rate
e.g. Hope House	*Treatment Group Home structured behavioral health treatment includes psychotherapy services*	*H0019*	*U2*	*$216.62*	*$0.00*	*$230.00*	

Is your agency enrolled with Medicaid?	☐ YES ☐ NO
If yes, in which States?	

Signature of Authorized Representative	
Title of Authorized Representative	
Printed Name of Authorized Representative	
Agency Name	
Date	
Phone	
Email	

Please provide a copy of your State's Medicaid letter showing your enrollment and your rate(s).

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.

As an authorized representative of this agency, I certify that the following is true regarding sanctions by the Centers for Medicare & Medicaid Services (CMS), formerly HCFA.

☐ This agency or individuals working for it have never been sanctioned by CMS.

☐ This agency or individuals working for it were sanctioned by CMS. The agency or individuals were sanctioned on (date) _____. Please select one option below.

- ☐ The sanctions have not been removed.
- ☐ The sanctions were removed on (date) _____. Please provide supporting documentation.

Signature of Authorized representative	
Printed Name	
Date	
Title	
Phone Number	
Email Address	
Agency Name	
Agency Address	
Agency City, State, Zip	

You may attach supporting documentation if necessary.

ACCREDITATION STATUS FORM

☐ This agency is not accredited.

☐ This agency is accredited. Documents confirming accreditation such as certificates are attached.

Agency Name	
Accrediting Organization(s), i.e. JCAHO, CARF, COA, etc.	
Period of Accreditation START Date	
Period of Accreditation END Date	

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, if applicable, included in the survey within each service area.

Signature of Person Completing Form	
Printed Name of Person Completing Form	
Date	
Phone Number	
Email address	

Please provide copies of accreditation certificate(s).