DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Invoice for Short-Term Group Home Assistance Payment

Beneficiary Information

Beneficiary Name _____
Last *First* *M.I.*

Date of Birth _____ Medicaid Number _____

Starting Month: LME-MCO:

Attestation of the beneficiary's eligibility by reviewing and checking the appropriate boxes below and that the Medicaid beneficiary received a denial letter and MOS was not/has not been granted.

☐ Eligible for Medicaid-covered Personal Care prior to January 1, 2013
☐ Determine to be ineligible for Personal Care Services on or after January 1, 2013
☐ Individual has continuously resided in a group home since December 31, 2012

Purpose of Assistance:
Check all that apply: ☐ Supervision ☐ Medication Management

_____ _____ _____
Authorized Provider Signature *Printed Name* *Date*

The Group Home Facility shall be responsible for the refund of all monies received if it is determined that the client was not qualified/eligible to receive payment for Personal Care Services.

Group Home Information

Medicaid Provider Number: _____ Tax ID Number: _____

Provider Name: _____ Group Home Name: _____

Group Home Site Address: _____
Street City Zip

Licensure Number: ☐ 10A NCAC 27G .5601(c)(1) Adult Facility MH ☐ 10A NCAC 27G .5601 (c)(3) Adult Facility I/DD

LME/MCO Review

Date Received by LME/MCO: Name and Signature of LME-MCO Reviewer:

DMH/DD/SAS

Date Received by DMH/DD/SAS: Name and Signature of DMH/DD/SAS Reviewer: