# **Invoice for Short-Term Group Home Assistance Payment**

## Beneficiary Information

|  |  |
| --- | --- |
| Beneficiary Name (Last, First M.I.) | Click or tap here to enter text. |
| Medicaid Number | Click or tap here to enter text. |
| Date of Birth | Click or tap here to enter text. |
| Month Requesting | Click or tap here to enter text. |
| LME-MCO | Choose an item. |

Attestation of the beneficiary’s eligibility by 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

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*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

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| --- | --- |
| Medicaid Provider Number |  |
| Tax ID Number |  |
| Provider Name |  |
| Group Home Name |  |
| Group Home FULL Address |  |
| Licensure Information | 10A NCAC 27G .5601(c)(1)  10A NCAC 27G .5601 (c)(3)  Licensure Number: Click or tap here to enter text.  Adult Facility MH Adult Facility I/DD  Child Facility MH  Child Facility I/DD |