

INSTRUCTIONS FOR COMPLETING THE ADULT CARE HOME SCU-A PRIOR APPROVAL FORM

1. Print this form in landscape orientation.
2. Print clearly.
3. All copies of items submitted must be legible.
4. The complete facility information is due only once per year according to the date on the care plan, or upon facility status change, or as otherwise needed.
5. AS REQUIRED BY HIPAA REGULATIONS, the completed form and information must be sealed in an envelope on which "CONFIDENTIAL" is written in red, and that envelope placed in another envelope and addressed. DMA will not accept faxed records.
6. Send the completed form via U.S. Mail to the following address:

Division of Medical Assistance
Facility and Community Care Section, ACH Unit
1985 Umstead Drive
2501 Mail Service Center
Raleigh NC 27699-2501

7. Direct questions to:
Tamara Derieux (1-919-855-4364) Tamara.Derieux@ncmail.net.
Linda Fisher, RN (1-919-855-4363) Linda.Fisher@ncmail.net

Must be mailed to:
 N.C. Division of Medical Assistance
 ACH Unit—Facility and Community Care
 1985 Umstead Drive
 2501 Mail Service Center
 Raleigh, N.C. 27699-2501

North Carolina
 Division of Medical Assistance
**SPECIAL CARE UNIT –A
 PRIOR APPROVAL**



PRINT CLEARLY

ACH Name _____ Street Address _____ City/Town _____ County _____
 Telephone _____ E-Mail _____ DHSR License # _____ Total # ACH Beds _____
 ACH Provider # _____ # SCU-A Beds _____ Freestanding SCU-A Yes No Other Specialty Designation _____

Resident Name _____ MID# _____ DOB: _____
 Date of Admission to SCU-A _____ New Admission to ACH Yes No Readmission to ACH Yes No
 New Admission to SCU-A Yes No Readmission with change of condition Yes No
 Resident is currently receiving Enhanced ACH/PCS Yes No Case Manager _____ Telephone: _____

The following information must be attached to this form for prior approval to be considered. (Submit only once a year according to the date on the care plan, or upon resident/facility status change, or as otherwise needed.)

A. Required Resident Information:

____ Current FL2 signed by a physician and showing a primary diagnosis of Alzheimer's and/or one of the following related disorders.

- | | | | | | |
|--------------------------|--------|------------------------|-------|-----------------------------|--------|
| • Alzheimer's Disease | 331.0 | • Parkinson's Disease | 332.0 | • Creutzfeldt-Jakob Disease | 294.10 |
| • Multi-Infarct Dementia | 290.4 | • Huntington's Disease | 333.4 | • Pick's Disease | 331.11 |
| • Lewy Body Dementia | 331.82 | | | | |

____ Pre-Admission Screening showing appropriateness for the recipient's placement in the SCU-A as required in 10A NCAC 13F.1306(2)

____ Copy of Care/Service Plan as required by policy as described in 10A NCAC 13F.1307

B. Required Facility Information:

____ SCU-A Disclosure Statement policy as described in 10A NCAC 13F.1306(3)

____ Current ACH License showing SCU-A designation as described in 10A NCAC 13F.1307

I certify that the above and attached information is correct and accurately represents the identified resident and the SCU-A program.

 Signature of Administrator

 Print Name Clearly

 Date

Revised 08/01/08