

Participant Name:

Medicaid ID:

CPOC: Begin Date:

End Date:

Louisiana Department of Health & Hospitals
Comprehensive Plan of Care EPSDT
- Targeted Support Coordination

CPOC Type: _____ Annual, Initial, Interim

Participant's Name:	Participant's DOB:	Region:
Social Security Number	Guardian:	
Medicaid Number:	Relationship:	
Address:	Address (if different) :	
City/State/Zip:	City/State/Zip:	
Home Phone: Other Phone:	Home Phone:	Other Phone:
Support Coordination Agency:	Provider Number:	
Support Coordination Agency's Address:	Contact Person:	
City/State/Zip:	Phone:	
Healthy Louisiana Agency:	Healthy Louisiana Agency Phone:	
Healthy Louisiana Agency:	Healthy Louisiana Agency Phone:	

Participant Name:

Medicaid ID:

CPOC: Begin Date:

End Date:

Sex: _____ 1. Male 2. Female

Race: _____ 1. White 2. Black/African American 3. Asian Pacific Islander 4. American Indian 5. Alaskan 6. Other

Education: _____ 01 Early Intervention 05 Regular and Special Education 09 Post-secondary: Colleg 13 Employed 98 N/A
02 Non-Categorical 06 Special Education Only 10 Post-secondary: Vocational 14 Unemployed 99 Other
03 Regular Kindergarten 07 Homebound Full Time 11 Pre-vocational Training 15 Working toward GED
04 Regular Education Only 08 Graduated 12 Supported Employment 16 Home Schooled

Legal Status: _____ 1. Competent Major 2. Minor 3. Interdicted -- Full 4. Interdicted -- Limited 5. Tutorship 6. Commitment 7. Custody 8. Other

ID: _____ Mild, Moderate, Severe, Profound, Special Needs

Adaptive Functioning: _____ Mild, Moderate, Severe, Profound, Special Needs

Diagnosis Code (ICD9) : _____

Residential Placement: _____ 01 Homeless 07 Community Home with 6 or less beds 13 Lives Independently with Other
02 Incarcerated 08 Supervised Apartment-OCDD Contract 14 Lives Independently Is
able to direct his/her own care: Yes, No

03 Temporary Quarters 09 Supported Living/Residential Habilitation 15 Psychiatric Facility
04 Nursing Home 10 Substitute Family Care 16 General Medical Facility
05 ICF/DD with 16 or more beds 11 OCS Foster Care 99 other
06 ICF/DD with 7 to 15 beds 12 Lives with Family/Friends

Names:
Number of other individuals in home who are ID/DD/Special Needs who receive Medicaid Services: _____

FOR LDH USE ONLY

CPOC Begin Date:

CPOC End Date:

Signature of DHH:

Date:

SECTION II: Medical/Social/Family History

Participant Name:

Medicaid ID:

CPOC: Begin Date:

End Date:

PAST: Pertinent Historical Information: (date age and Cause of disability. If not known, put unknown. Placement situations that impact care; response to interventions in the past summary of events leading to request for services at this time.)

PRESENT: Describe Current Living Situation: (describe current family situation; identify all available natural supports; identify family's understanding of individual's situation/condition - knowledge of disability and consequences of non-compliance with CPOC; economic status; relevant social environmental and health factors that impact individual (i.e., health of care givers; home in rural/urban area; accessibility to resources; own home/rental/living with relatives/extended family or single family dwelling. Does home environment adequately meet the needs of individual or will environmental modifications be required ?)

HEALTH STATUS:

Physician Name: _____

Date of Last Appointment: _____

Immunizations Current: Yes No

Medical Diagnoses and Concerns/Significant Medical History:
(Include findings of last physical)

Dates of Evaluations/Documentation used to develop this CPOC

- _____ Social
- _____ Psychological
- _____ Psychiatric
- _____ Special Education
- _____ Individual Education Plan
- _____ Behavior Management Plan
- _____ Home Health Plan of Care
- _____ 90 or Medical Records
- _____ SOA
- _____ Pediatric Day Health Care P

SOA Permanent

_____ Other _____

Psychiatric/Behavioral Concerns:

Information included on this page is relevant to the individual's life today and provides a means of sharing medical/social/family history not addressed in the content of the CPOC. Include information that is important to share and relevant to supporting and achieving the goals determined by the person.

SECTION III: CPOC SERVICE NEEDS AND SUPPORTS

Participant Name:

Medicaid ID:

CPOC: Begin Date:

End Date:

Service Strategy/	Description	How was need determined?	Why Not? Requested by participant/family	Goal(s)	Receiving Service Medicaid School Community Family OCDD Requires PA tracked by S. C.	Amount Approved
Personal Care Serv			<input type="checkbox"/>		<input type="checkbox"/>	
Extended Hme Serv			<input type="checkbox"/>		<input type="checkbox"/>	
DME			<input type="checkbox"/>		<input type="checkbox"/>	
OT			<input type="checkbox"/>		<input type="checkbox"/>	
Physical Therapy			<input type="checkbox"/>		<input type="checkbox"/>	
Speech Therapy			<input type="checkbox"/>		<input type="checkbox"/>	
Behavioral Health ReHab			<input type="checkbox"/>		<input type="checkbox"/>	
Dental Services			<input type="checkbox"/>		<input type="checkbox"/>	
Psch/Behav. Serv			<input type="checkbox"/>		<input type="checkbox"/>	
Specialty Eyewear			<input type="checkbox"/>		<input type="checkbox"/>	
NEMT			<input type="checkbox"/>		<input type="checkbox"/>	
Air Ambulance			<input type="checkbox"/>		<input type="checkbox"/>	
Out-of-State Care			<input type="checkbox"/>		<input type="checkbox"/>	
Organ Transplants			<input type="checkbox"/>		<input type="checkbox"/>	
Diapers			<input type="checkbox"/>		<input type="checkbox"/>	
School			<input type="checkbox"/>		<input type="checkbox"/>	
Vocational			<input type="checkbox"/>		<input type="checkbox"/>	
Employment			<input type="checkbox"/>		<input type="checkbox"/>	

Participant Name:

Medicaid ID:

CPOC: Begin Date:

End Date:

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies in addition to the therapies received at school through the IEP. Yes No If not why not:

Support Coordinator has reviewed the Medicaid Services Chart with me: Yes No If not why not:

Support Coordinator has provided me with information on Medicaid EPSDT Services: Yes No If not why not:

Support Coordinator has provided me with information on EPSDT Screening Services: Yes No

If not why not:

EPSDT Screening Services requested: _____

I have reviewed and agree with the services contained in this plan. I understand it is my responsibility to notify the Support Coordinator of any change in my status which might affect the effectiveness of the services provided. I further agree to notify the Support Coordinator of any change in my income which might affect my child's financial eligibility. I understand the services in this plan of care are not authorized by the Support Coordinator and the services may begin as soon as I am notified of their approval whether or not this plan of care has been approved.

Participants/Guardian's Signature _____

Date

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant's need and that that services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed.

If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

Support Coordinator's Signature _____

Date

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required

Support Coordinator Supervisor's Signature _____

Date

SECTION VI: CARE PLAN ACTION

Participant _____ Name:Date Approvable CPOC Rec'd by LDH:

CPOC Status: _____

Approval or denial of this CPOC does not approve or deny any of the services the participant may be eligible for, and only addresses the Support Coordinator's required services implementation and documentation.

Approved CPOC: Begin Date: ~~me~~ _____

Signature/Title of LDH Representative: _____

Notes:

Notes:

Section VI: Typical Weekly Schedule

Confidential

For Planning Purposes Only. If needs change, I will contact my case manager as soon as possible.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE
F = Family/Friends
S = Self
Sc = School
ST = Speech Therapy
OT = Occupational Therapy
PCS = EPSDT Personal Care Services
EHH = Extended Home Health
PT = Physical Therapy

COMMENTS:

Above is the schedule of services requested by the individual and should be provided at these times. PCS can be provided at the same time as skilled nursing or therapy services as long as the PCS worker is performing duties that do not require one-on-one contact with the participant such as meal preparation and cleaning but should never be idle during the time they are billing for services. On rare occasions PT and OT can be performed concurrently when the provisions of services in this manner is determined to be more effective treatment. Otherwise, there should not be concurrent services provided to the participant.

Participant Name: _____ CPOC Begin Date: _____ End Date: _____

Issued May 30, 2003
Revised August 7, 2008

LSCIS CPOC Section 1

Demographics/ Contact Information

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Case #: Name: Last First MI Target: Vent. Dep.: DCFS/OCS; S. C.

Physical MCO Agency:
Behavioral MCO Agency:

[Contact Information](#) [Demographic Information](#) [Closure Information](#) [Pa History](#) [CPOC History](#) [Tracking History](#)

Client SSN: Medicaid ID:
This Medicaid Number does not match the medicaid number on the most recent PA (9070545607947)

Parish: Region:
Date of Birth: Age:
Case Open:
Sex: Race:
Legal Status:
Is able to direct his/her own care:
ID: Adaptive Functioning:
Residential Placement:
Number of ID/DD/Special Needs in Home (excluding recipient):
Names:
Current Education/Employment:
Non-Chisolm reason:
ICD10 Diagnosis:

LSCIS CPOC Section 2 – Medical/Social/Family History

- Contact Information
- Demographic Information
- Closure Information
- Pa History
- CPOC History
- Tracking History

Cpoc History

Cpoc Type	Support Coordinator	Submit for review by LDH	Submit Date	Approval Status	Reviewer	Begin Date	End Date	Q.R. Date	Edit	Void	Void	Print
Interim	MAH Marcia Hardy	<input type="checkbox"/>				02/10/2018	02/09/2019			<input type="checkbox"/>	Void	

- 2. Medical/Social/Family History
- 3. CPOC Service Needs and Supports
- 4. CPOC Participants
- 5. CPOC Approval Information
- CPOC Quarterly Review
- Approval Denial Notes History

PAST: Pertinent Historical Information

PRESENT: Describe Current Living Situation and Natural Supports:

HEALTH STATUS

Physician: Last Appointment Date :

Immunization Current:

Medical Diagnoses and Concerns/Significant Medical History (Include findings of last physical):

Psychiatric/Behavioral Concerns:

Dates of Evaluations/Documentation used to develop this CPOC

<input type="text" value="//"/>	Social Evaluation
<input type="text" value="//"/>	Psychological Evaluation
<input type="text" value="//"/>	Psychiatric Evaluation
<input type="text" value="//"/>	Special Education Eval.
<input type="text" value="//"/>	Current IEP
<input type="text" value="//"/>	Behavior Management Plan
<input type="text" value="//"/>	Home Health Plan of Care
<input type="text" value="//"/>	Form 90 or Medical Records
<input type="text" value="//"/>	Pediatric Day Health POC
<input type="text" value="//"/>	SOA
Expiration: <input type="text" value="//"/>	
Permanent: <input type="checkbox"/>	
<input type="text" value="//"/>	Other
Describe: <input type="text"/>	

LSCIS CPOC Section 3 – CPOC Service Needs and Supports

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[Denied CPOCs](#)

Case #: 00001 Name: Last Doe First John MI L Target: ETP Vent. Dep.: DCF5/OCS: S. C. MAH
 Physical MCO Agency:
 Behavioral MCO Agency:

Contact Information | Demographic Information | Closure Information | Pa History | CPOC History | Tracking History

CPOC History

CPOC Type	Support Coordinator	Submit for review by LDH	Submit Date	Approval Status	Reviewer	Begin Date	End Date	Q.R. Date	Edit	Void	Print
Interim	MAH Marcia Hardy	<input type="checkbox"/>				02/10/2018	02/09/2019		<input type="button" value="Edit"/>	<input type="button" value="Void"/>	<input type="button" value="Print"/>

2. Medical/Social/Family History | 3. CPOC Service Needs and Supports | 4. CPOC Participants | 5. CPOC Approval Information | CPOC Quarterly Review | Approval Denial Notes History

Service Needs

Service Strategy/Description	How was Need determined	Requested by participant/family	If not why not?	Primary Goal	Receiving	Medicaid	School	Community	Family	OCDO	Requires PA tracked by S. C.	Amount Approved	Void	Edit
Other (7) APE	IEP	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Other (6) Gastro	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Other (5) ENT	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Other (4) Allergist	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Other (3) FSA: Samsung tablet	Family	<input type="checkbox"/>	Family does not want		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Diapers (1) Incontinence Supplies	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Other (1) Development Specialist	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Dental Services (1) Routine Check up	Family	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Speech Therapy (1) Communication	IEP	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
OT (1) Motor Skills	IEP	<input checked="" type="checkbox"/>		Best possible health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input type="checkbox"/>	<input type="button" value="Edit"/>
Other (8) Example to void	Family	Void <input type="checkbox"/>	Void	Void	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/	<input checked="" type="checkbox"/>	<input type="button" value="Edit"/>

LSCIS CPOC Section 4 – Additional Information / CPOC Participants

2. Medical/Social/Family History
 3. CPOC Service Needs and Supports
 4. CPOC Participants
 5. CPOC Approval Information
 CPOC Quarterly Review
 Approval Denial Notes History

Planning Participants:	Title and Agency Name:

Additional Information about Service Needs and Supports:

S. C. has explained that Medicaid will provide medically necessary therapies, in addition to the therapies received at school through the IEP.

If no why not:

Support Coordinator has reviewed Medicaid Services Chart with the participant and family: If no why not:

Support Coordinator has provided the participant and family with information on Medicaid EPSDT Services: If no why not:

Support Coordinator has provided the participant and family with information on EPSDT Screening Services:

If not why not:

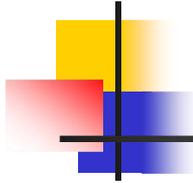
EPSDT Screening Services requested: If yes referral Date:

Participant Signature Date:

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the participant receives the services he or she needs to attain or maintain their personal outcomes. The Support Coordinator will have phone contact with the family/participant at least monthly and meet face to face at least quarterly to assure that the CPOC continues to address the participant's need and that that services are being provided. The CPOC will reviewed by the Support Coordinator at least quarterly and revised annually and as needed. If there are no services to coordinate, the family/recipient has been informed of this and that they can access support coordination at any time until the child's 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry.

Signature of Support Coordinator: S.C. Signature Date: Ready for Supervisor Review:

LSCIS CPOC Section 5 – CPOC Approval Information



Contact Information
 Demographic Information
 Closure Information
 Pa History
 CPOC History
 Tracking History

Cpoc History

Cpoc Type	Support Coordinator	Submit for review by LDH	Submit Date	Approval Status	Reviewer	Begin Date	End Date	Q.R. Date	Edit	Void	Print
Interim	MAH Marcia Hardy	<input type="checkbox"/>				02/10/2018	02/09/2019			<input type="checkbox"/> Void	

2. Medical/Social/Family History
 3. CPOC Service Needs and Supports
 4. CPOC Participants
 5. CPOC Approval Information
 CPOC Quarterly Review
 Approval Denial Notes History

I, the Support Coordinator Supervisor, have reviewed all of the listed evaluations/documentation used to develop this CPOC, service logs, and quarterly reviews for identified needs and the status of requested services. The entire CPOC was reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

Signature Support Coordinator Supervisor Date:

Submit for review by LDH: See Service Tickets

Approval/Denial Information

By: Approval/Denial Date:

Approval/Denial Notes:

LSCIS CPOC Quarterly Review

2. Medical/Social/Family History		3. CPOC Service Needs and Supports		4. CPOC Participants		5. CPOC Approval Information		CPOC Quarterly Review		Approval Denial Notes History	
Service Needs	Requesting Services	Receiving Services	Expiration Date of PA	Referred to PAL	Appeal Process	Progress Status of Service/ Receiving amount PA					
Dental Services (1) Routine Check up	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Diapers (1) Incontinence Supplies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>									
OT (1) Motor Skills	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Other (4) Allergiest	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Other (6) Gastro	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Other (1) Development Specialist	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Other (3) FSA: Samsung tablet	<input type="checkbox"/>	<input type="checkbox"/>	NA	NA	NA						
Other (5) ENT	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Other (7) APE	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Speech Therapy (1) Communication	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	NA	NA	NA						
Health Changes (Include Nutritional Changes)											
Safety Issues											
Changes in Living Situations											
Medicaid Services Chart											
Rights and Responsibilities											
Grievance Policy											
Abuse Policy											
Health Standards Provider compliant (1-800-660-0488)											
Medicaid Managed Care Program Assistance/ Compliance Line (1-888-342- 6207)											
Are you requesting any medically necessary therapies now or want to receive therapies on the IEP during the school's summer break?											
Participant Questions											
Are you receiving the services that you requested?	<input type="checkbox"/>	Participant Compliant Form Completed									
Are the Services at the day/time needed?	<input type="checkbox"/>										
Are you pleased with the services that you are receiving?	<input type="checkbox"/>										
Are there Additional services that you need?	<input type="checkbox"/>										
Notes(Include narrative description of Above CMIS codes, additional explanations as needed and summary status and progress for quarter)											
Support Coordinator:	<input type="text"/>	Date:	<input type="text"/>								
Names of Attendees	Relation/Title/Agency	Date									
<input type="text"/>		///									
<input type="text"/>		///									
<input type="text"/>		///									
<input type="text"/>		///									
<input type="text"/>		///									
<input type="button" value="Edit"/>											

LSCIS Prior Authorization Tracking Log

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[Denied CPOCs](#)

Case #: 00001 Name: Last Doe First John MI L Target: ETP Vent. Dep.: DCFS/OCS: S. C. MAH
 Physical MCO Agency:
 Behavioral MCO Agency:

[Print](#)

[Contact Information](#) | [Demographic Information](#) | [Closure Information](#) | [Pa History](#) | [CPOC History](#) | [Tracking History](#)

Support Coordinator: Type of Service Requested: Type Of Request: Amount of Requested service: Date of Service Request:
 Date of COP: Provider: Date of Referral to Provider/MMCCM: 15 Day Provider/MMCCM Contact Date: 35 Day Provider/MMCCM Contact Date:
 Date Packet Submitted to Date Provider PA Request Packet Received: Not Received: Date of Referral to PAL (Untimely PA Packet Submission): Date of Decision: Date PA Notice Received: Date of Referral to PAL (Untimely PA Notice): Amount of Service Approved:
 PA Begin Date: PA End Date: Service Start Date: PA Issued within 60 Days of Request: NA Explanation, if not issued: Date Renewal Sent and new tracking started: Date Denial of Service Notice Received:
 Approval/Denial Status: Reason for Denial: Date Appeal Rights Explained: Date Appeal Brochure Provided: Offered to help with appeal Date: Is Client Appealing:
 Request Assistance with Appeal: Date Appeal Sent to LDH: 20 Day Appeal Follow Up: 90 Day Appeal Follow Up: Date of Appeal Decision: Appeal Outcome:
 Notes:

LSCIS Prior Authorization Tracking Log for Medicaid Managed Care Program Services

Medicaid Managed Care Program **Medicaid Managed Care Program**

Contact Information
 Demographic Information
 Closure Information
 PA History
 CPOC History
 Tracking History

Support Coordinator:
 Type of Service Requested:
 Type Of Request:
 Amount of Requested service:
 Date of Service Request:

Date of COP:
 Provider:
 Date of Referral to Provider/MMCCM:
 15 Day Provider/MMCCM Contact Date:
 35 Day Provider/MMCCM Contact Date:

Date of 2nd Referral to Provider/MMCCM:
 2nd 15 Day Provider/MMCCM Contact Date:
 2nd 35 Day Provider/MMCCM Contact Date:

Date Packet Submitted to
 Date Provider PA Request Packet Received:
 Not Received:
 Date of Referral to PAL (Untimely PA Packet Submission):
 Date of Decision:
 Date PA Notice Received:
 Date of Referral to PAL (Untimely PA Notice):
 Amount of Service Approved:

PA Begin Date:
 PA End Date:
 Service Start Date:
 PA Issued within 60 Days of Request: NA

 Explanation, if not issued:
 Date Renewal Sent and new tracking started:
 Date Denial of Service Notice Received:

Approval/Denial Status:
 Reason for Denial:
 Date MCO Appeal Rights Explained:
 Offered to help with MCO Appeal Date:
 Is Client Appealing:
 Request Assistance with MCO Appeal:
 Date Appeal Sent to MCO:

20 Day MCO Appeal Follow Up:
 Date of MCO Appeal Decision:
 MCO Appeal Outcome:
 MCO Appeal Notes:
 Date Appeal Rights Explained:
 Date Appeal Brochure Provided:
 Offered to help with appeal Date:
 Is Client Appealing:

Request Assistance with Appeal:
 Date Appeal Sent to LDH:
 20 Day Appeal Follow Up:
 90 Day Appeal Follow Up:
 Date of Appeal Decision:
 Appeal Outcome:

Notes:

LSCIS Service Log

LSCIS Service Log Form V 3.45 Site: 0299030 Thursday, March 17, 2016 [Log Out: Sally](#)

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[Denied CPOCs](#)

Ticket No: Case No: S. C.

1. Date: 5. Activity: P/P Contact

2. Begin Time: : End Time: :

3. Place: 7. Service Participants:

4. Type of Contact:

Entered: Modified: Reviewed:

8. Begin Mileage: End Mileage:

9. Minutes spent documenting log:

Service Need:

Notes: