NC MEDICAID
HIV CASE MANAGEMENT (HIV CM)
Provider Recertification Application

Policy References in this document are in regard to Clinical Coverage Policy No: 12B HIV Case Management.

SECTION 1: DEMOGRAPHIC INFORMATION

Provider Contact Information

Agency Name:		
Application Date:	Office Phone:	Office Fax:
Certification Site Address:		
City:	State:	ZIP Code:
Mailing Address:		
City:	State:	ZIP Code:
Agency E-mail Address:		

Point of Contact Information

Agency Contact Name and Title:		
Phone:	E-mail:	Fax:

Owner / Director Contact Information

Owner / Director Contact Name and Title:		
Phone:	E-mail:	Fax:

Preparer Contact Information (Individual Completing the Application)

Preparer Contact Name and Title:		
Phone:	E-mail:	Fax:

SECTION 2: GENERAL REQUIREMENTS

1) Action:

List the names of all current HIV Case Management staff with hire dates.
Exclude supervisors in this section.

Name of Case Manager:	Date of Hire:

2) Action:

List the names of all current HIV Case Management Supervisors with hire dates.

Name of Case Manager:	Date of Hire:

3) Action:

List the counties in which your Agency/Organization provides HIV Case Management services:

4) Action:

List all services provided through your Agency/Organization: (i.e. Substance Abuse Counseling, etc.)

5) Action:

What are your agency's hours of operation for providing HIV Case Management?
How do you provide for client coverage when the HIV Case Managers are out of the office or the agency is closed (Emergency after hours' plan)?

6) Action:

By which approved body is your agency accredited?
What is the accreditation effective and expiration date? If not currently accredited, explain below.

7) Action:

How frequently does your Agency administer the satisfaction survey tool? How are these results used?

8) Action:

How many active HIV Case Management clients does your agency currently serve through Medicaid and /or Ryan White? Provide the total Medicaid case management clients and the total Ryan White case management clients.

SECTION 3: ATTACHED DOCUMENTS

1) Action:

If any of the following policies, a - k, have changed since the last certification period, include a copy of each with your submission.
If there are no changes in a policy since your last certification, list the relevant policy effective date in C*omments* on the *Recertification Application Checklist* and do not include a copy of the document.

a) Confidentiality; b) Beneficiary grievance policy; c) Beneficiary rights policy, d) Non-Discrimination Policy; e) Code of Ethics; f) Conflict of Interest Policy;	g) Electronic records policy; h) Medical records, including retention; i) Freedom of choice; j) Transfer and discharge policy; and k) Identification of abuse, neglect, and exploitation policy.

Notes:

2) Action:

If any of the following, a – h, have changed since the last certification period, include a copy of each with your submission.
If there are no changes in an item since your last certification, please state so in C*omments* on the *Recertification Application Checklist* and do not include a copy of the document.

a) Quality Assurance Policy
b) Quality Assurance chart review results since the agency's last certification.
c) Current organizational chart including all HIV CM staff;
d) Community resources;
e) Persons with 5% or more ownership in all or one agency;
f) Submit copies of all HIV CM and supervisor credentials;
g) Plan for networking with CCNC or the PCP;
h) Any HR Policies, Procedures, or Plans, as specified in 6.2.3.c of Clinical Coverage Policy 12B.

Notes:

SECTION 4: COMPLIANCE

- ✓ The agency/organization agrees that NC Medicaid may review beneficiary records and any other HIV Case Management information as part of the overall monitoring and evaluation of the program and agrees to submit to an on-site recertification visit.
- ✓ It is the responsibility of the provider to verify staff background qualifications and credentials prior to hiring, and assure during the course of employment, that the staff member continues to meet the requirements set forth in this policy.
- ✓ The agency/organization agrees to provide regular monitoring by a supervisor who meets the requirements as specified in policy.
- ✓ Provider must maintain a business plan and computer capabilities to comply with clinical policy mandates.
- ✓ Providers shall comply with all applicable federal, state, and local laws; regulations; and agreements, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Signing below indicates that your agency/Organization agrees with the above and certifies that the information contained in this application is true and accurate to the best of your knowledge.

Typed/Printed Name of Preparer	Typed/Printed Name of Owner/Director
Signature of Preparer	Signature of Organization Director
Date	Date