DHS Oregon Department of Human Services

Seniors and People with Disabilities

Information Memorandum Transmittal

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Authorized Signature

Number: **SPD-IM-10-062**
Issue Date: 7/29/2010

Topic: Developmental Disabilities

Subject: New DD Foster Care Data Change Form (SDS 4547)

Applies to (check all that apply):

- ☐ All DHS employees
- ☐ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☒ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☐ Seniors and People with Disabilities
- ☒ Other (please specify): DD CDDP Services Coordinators, SPD DD Regional Coordinators; DD Provider Technical Assistance Unit; DD Contracts Adminstration Unit; Paul Campos.

Message: As discussed in SPD-AR-10-024 Foster Care Absence Notification Procedures, use of the 0337 form and Foster Care Data Change form is necessary when reporting client absences from foster care services.

SPD has revised and updated the DD Foster Care Data Change Form, and has added fields on the form specifically for reporting client absence information.

Effective immediately, CDDPs shall use the new DD Foster Care Data Change form with the 0337 form to report client absences from foster care services.

The electronic version of the new DD Foster Care Data Change form and its instructions are now available for download at the Oregon DHS Forms website. Enter the form number "4547" in the form number search field to take you to the form.

Copies of both for are included with this transmittal your reference.

If you have any questions about this information, contact:

Contact(s):	Kim Wise, DDSCU Business Analyst		
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E-mail:	Kim.m.wise@state.or.us		

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
Provider Payments Unit

DD Foster Care Data Change Form

Resident name: _____ AFS prime number: _____

1. Type of foster care:

☐ **Child** (age 17 and under) ☐ **Adult** (age 18 + in AFC)

☐ **Adult** (age 18 – 21 ***but still in child certified foster care***)

2. Type of action:

☐ **New placement** Date: _____

☐ **Termination** Date: _____

(Provider will be paid through the date prior)

Child Only – reason for termination: _____

☐ **Bed hold payment authorization reason:** **{Select One}** _____

Date out of residence: _____ Date returned to residence**:** _____

☐ **Change:**

- ☐ Service rate change Date: _____
- ☐ Current provider address change Date: _____
- ☐ Change to new provider Date: _____

3. County of payment: { B - J } { K - Y } _____

4. Resident service rate

Monthly foster care provider rate: $ _____

Monthly total consultant rate(s): $ _____

Total monthly foster care service rate: $ _____

5. Provider information:

New	**Previous**
Name: _____	Name: _____
Site address: _____	Site address: _____
City/ZIP: _____	City/ZIP: _____
Mailing address: _____	Mailing address: _____
City/ZIP: _____	City/ZIP: _____
Phone: _____	Phone: _____
Provider Medicaid #: _____	Provider Medicaid #: _____

6. Signature

_____ _____ _____

(County service coordinator signature) *(Date)* *(Phone)*

7. *E-mail address:* _____

Client Medicaid eligibility determination and coding must be completed before payment can be generated.

A. Submit: SDS 4547 to your local DSO, SPD office; **or**
FAX to: Children Medical Eligibility Unit (CMEU) 503-378-5588; **or**
E-mail: apps.cmeu@dhs.state.or.us

AND

B. Submit: DHS 0337 and SDS 4547 to DD Enrollment Unit:
FAX: 503-947-5044 **or** e-mail: DD-Eligibility.Enrollment@state.or.us

Instructions for the
DD Foster Care Data Change Form

Purpose: One of the informational form(s) used for data entry to generate a DD Foster Care Payment.

Other forms used:
DHS 0337 DD Eligibility and Enrollment Form
DHS 0520 TXIX Waiver Form

Resident name: Enter client/residents name. **AFS prime number**: Clients Prime number

1) **Type of foster care:**

- ***Child*** (*17 and under*): For individuals who are children aged 0–17 years of age. There will be additional children's foster care forms that will need to be completed. Work with children's foster care coordinator at SPD to complete the enrollment packet for children entering foster care.

- ***Adult*** (*age 18–21 but still in children's certified foster care*): Select this if the individual is aged 18–21 and has a variance to remain in a children's certified foster care placement.

- ***Adult*** (*18+*): Select this for individuals aged 18 and older who are receiving licensed adult foster care services.

2) **Type of action:** *Note: The dates are very important in ensuring payment is processed.*

New placement: Date client entered Foster Care. Also to be used when transfer(s) from another county occur.

Termination: Select this when you are ending an individual's foster care services (even if the individual is transferring to foster care in another county), or changing from foster care to another service type (from foster care to a group home). Terminations will also need a corresponding DHS0337 form and if permanently terminating comprehensive services the DHS0520 TXIX Waiver form must also be submitted. When children are terminated from services note the reason the child left services.

Bed hold payment authorizations: Select the reason for the bed hold from the drop down options. Enter the date the client left the residence and the date the client returned to the residence. The information entered in this section should match the bed hold information entered in section 7 of the DHS0337. (Note: Client information, county of payment, rate, provider information and service coordinator name are required when submitting the SDS4547 form for a bed hold payment authorization.)

Change: Check the appropriate box and date action(s) is needed.

3) ***County of payment:*** This is the county that the payment is being funded through. Select a county from the drop down list.

4) ***Resident service rate:*** Enter the amount of the individual's foster care service rate. If the individual also has consultant funds included in their rate (for example, for behavior consulting), please list that amount separately.

5) ***Provider information:*** List the provider's name, the foster home site address, provider's mailing address, phone, and six (6) digit Medicaid provider number here. If you have selected "change to a new provider" then list the old provider information as well as the new provider information where indicated. If you have selected "provider address change" please indicate the new and old address, either site and/or mailing, which ever the change applies to.

6) ***County service coordinator signature:*** Sign, date, add phone number and email address of the service coordinator/case manager completing the form.

7) ***FAX/e-mail the form:*** The completed form needs to be faxed/emailed to **BOTH** the Medicaid office (formerly known as the "DSO") and to the DD Eligibility and Enrollment Unit (include DHS0337 and DHS0520 if appropriate).

Additional information:

1. For individuals who leave foster care temporarily and payment must be stopped in accordance with contracting/payment restrictions (for example: an individual who is in jail longer than five days, hospitalized for longer than 90 days, etc. and payment needs to stop until the individual returns), you'll need to submit a data change form indicating "**termination**" to stop the payment.

   When the individual returns to foster care services after one of these temporary periods when payment isn't made, you'll need to submit a new data change form, and select "**new placement**" and the new date to start the payment to the provider again, even though the individual may most likely be returning to the same provider at the same rate.

2. Keep a copy of all data change forms that are completed and submitted for individuals, and verification that you have faxed/sent to the DD Eligibility and Enrollment Unit (for example, a copy of the fax verification).