

LOUISIANA MEDICAID INSPECTION / MONITORING REPORT

Application Center Name: _____ AC ID#: _____

AC Satellite Office Name (If applicable): _____

Application Center Street Address: _____

Application Center P.O. Box: _____

AC Telephone Number: (____) _____ AC Fax Number: (____) _____

Name of Administrator/CEO: _____

AC E-mail Address: _____

SECTION ONE: INTERVIEW WITH ADMINISTRATOR/CEO

Name of Person Interviewed: _____

Title: _____

SECTION TWO: PHYSICAL PLANT

Does the reception area (if applicable) have adequate seating for Medicaid applicants? Yes No

Does the interview area have accommodations for privacy of conversation and intake? Yes No

Does the AC meet current ADA requirements? Yes No

SECTION THREE: CERTIFICATION

NOTE: *DHH monitor will view AC copies of *Certification Letters, Certificates, and Confidentiality Agreement(BHSF AC-3)*. DHH monitor will verify that all Confidentiality Agreement Forms were signed by Application Center staff within the most recent year.

Name of Contact Person: _____

AC Representative	Certification Date	Certification Letter or Certificate on file?*	Confidentiality Agreement BHSF AC-3 on file?*
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Use additional sheet to list AC Representatives, if necessary.)

Does the AC use the online application? Yes No

If not, then does the AC have a current copy of the AC Handbook or Internet access? Yes No

Is DHH Representative's Name / signature on the most recent *Contractual Agreement*? Yes No

Is authorized signer on the *Contractual Agreement* still employed by the AC? Yes No

If no, give name of the new authorized individual: _____

SECTION FOUR: APPLICATIONS

Estimate the number of interviews conducted per month: _____. Can AC do more? Yes No

If yes, explain: _____

What is the source of AC's referrals? _____

Where does AC send verifications received from the applicant? _____

Is a Medicaid Application Center sign posted? Yes No

Is the sign legible? Yes No

Is the information specific to applicant/clientele being served? Yes No

Is the sign visible to the public? Yes No

Are interviews completed within **five (5) working days** from initial contact with applicant? Yes No

Does the AC have pre-addressed envelopes to provide to the applicant? Yes No

If time frame cannot be met, are applicants referred to another AC or DHH office? Yes No

Were Logs of Referral reviewed by DHH monitor to verify that referrals are being made? Yes No

Are *Rights, Responsibilities, and Benefits* of programs explained to applicants? Yes No

How was this determined? Observed AC Representative assisting applicant;
 Statement from Certified AC Representative; or,
 Statement from Administrator or CEO.

Comments: _____

SECTION FIVE:

CORRECTIVE ACTION

Is corrective action necessary at this time?

Yes No

If yes, explain: _____

NOTE: If the Application Center feels it may have been treated unfairly during the monitoring process, the Louisiana Department of Health and Hospitals will provide an opportunity for an impartial review.

Signature of DHH/BHSF Representative

Date

Signature of Application Center Official

Date

FOR DHH/BHSF USE, ONLY
COMMENTS: _____