REQUEST FOR PROPOSALS (RFP)
REHABILITATIVE CLAIMS SUBMISSION AND PROVIDER REVIEWS
OBF/GMD/13-001-S

Amendment No. 2

May 31, 2012

Prospective Offerors:

This amendment is being issued to amend certain information in the above named RFP. All information contained herein is binding on all Offerors who respond to this RFP. Specific parts of the RFP have been amended. The changes are listed below. New language has been double underlined and marked in bold (i.e., **word**) and language that has been deleted has been marked with a strikethrough (i.e. ~~word~~).

1. Section 3.5.2.3 Security Requirements for Electronic Submission of Claims:
   Amended B. 1 ~~Contractor and DHR Administrators/Project Managers shall:~~ **DHR Administrators/Project Managers shall:**

2. TABLE OF CONTENTS – Section VI Appendicies
   Added Attachment J – Sample Attendance Sheet and Instructions
   Added Attachment K – Provider Review Tool

3. SECTION VI. APPENDICIES
   Added Attachment J – Sample Attendance Sheet and Instructions
   Added Attachment K – Provider Review Tool

Should you require clarification of the information provided in this Amendment, please contact me via email at aung.htut@maryland.gov or by telephone at (410) 767-7775.

By:
Aung Htut
Procurement Officer

State of Maryland
PURCHASE OF RESIDENTIAL CARE - ATTENDANCE SHEET
LOCAL DEPARTMENT OF SOCIAL SERVICES

SERVICE MONTH: July-12

NOTE: TFC = Therapeutic Foster Care
RGH = Residential Group Home

FACILITY NAME: XXXXX
COUNTY CODE: 02
PROVIDER ADDRESS: xxxx Green St
PROVIDER TELEPHONE #: xxx-xxx-xxxx
PROVIDER CITY, STATE, ZIP: Annapolis, Maryland 21209
EMAIL ADDRESS:
PROVIDER CONTACT PERSON: Xxxxxx Yyyyy
Provider Tax ID #: xxxxxxxxxx

AGENCY: DHR
Anne Arunde County DSS
ADDRESS:
CITY, STATE, ZIP:

NAME (Last)	NAME (First)	Chessie Client ID #	Medicaid Client ID#	Date of Birth	SSN	TFC or RGH	PROGRAM NAME	Provider MMIS #	TOTAL DAYS IN PROGRAM THIS MONTH BEGIN	TOTAL DAYS IN PROGRAM THIS MONTH END	DAILY ATTENDANCE FOR THE INVOICE MONTH (Y OR N REQUIRED FOR EACH DATE FROM BEGIN TO END) 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aaaaa	Bbbbb	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/30/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ccccc	Dddd	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Eeeee	Ffffff	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12																					Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Gggggg	Hhhhhh	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Iiiiii	Jjjjjj	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y
Kkkkk	Llllll	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mmmmm	Nnnnnn	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y
Oooo	Pppp	xxxxxxx	xxxxxxxxxxx	xx/xx/xx	xxx-xx-xxxx	TFC	XXXXX	xxxxxxxxx	07/01/12	07/31/12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y																	

Sample Attendance
May 22, 2013
A. Abel-Tongue

Attendance Invoice Instructions:

1. In the upper portion of the form, complete all of the "Required" items for your organization.

Note:A new addition to the Attendance Invoice is the "County Code". Please select the appropriate placement County that corresponds to your Agency provided in the drop down box located next to the DHR agency information.
In the "Provider ID " box, we request that you enter your Federal Tax Identification Number.

2.Complete all of the items in the yellow on the lower portion of the form.
This information is of vital importance to the completion of the claim, please review this data to ensure the accruacy of your entries.
Additional forms will be required if there are more than 65 children in the facility.

3. Enter the "Begin" and "End" dates that each child was in the program for the month being invoiced.
This will include overnight stays outside of the facility, as long as the child was not discharged.
(Ex: if a child was in placement for the entire month, enter the first and last dates of the month).

4. Complete the Daily Attendance section for each child. If the child was PHYSICALLY in the facility, enter "Y". If the child was absent overnight ((e.g., home visit), enter "N".
Data input is necessary in order to accurately transfer attendance information to the invoice.

5. Review for accuracy to include verifying that no error codes are noted.

6. Select the tab marked "Invoice". Information entered on the Attendance Sheet automatically entered on the Invoice form.

7. Save file in the following format: PROVIDERNAME-DSSMMYY (e.g., GroupHome-BDSS0308). Rename the file each month.

8. E-mail the file by the 10th of each month to: MdRehab@dhr.state.md.us

9. Please do not email attendance sheets to the program contact person.

10.Please do not manipulate the attendance sheet in anyway this will complicate the way in which we tally our claims data from the attendance sheet.

Revised September 2012

Rehabilitation Option Services
Review For Federal and State Requirements

Facility _____ Provider ID _____ Review Date: _____

Client Name: _____ Client MA ID _____

Facility Type: TFC ___/RGH ___

Client Information

Claim Date From _____ Claim Date To _____

Admission Date _____ Discharge Date _____

Initial Assessment Date: _____

Reviewer to verify documentation in support of the requirements listed below is maintained in the recipient's file and is effective for the claiming period.

1. **Assessment identifying an eligible diagnosis and completed by a LHSP?** Y N

Date Completed _____
Name and credentials of LHSP _____
Document(s) maintained as evidence of Assessment _____

Documentation the recipient received the prescribed services Y N

Date Completed _____.
Document(s) maintained as Service Documentation _____

2. **Written, dated & signed Individual Treatment Plan addressing the recipient's eligible diagnosis, completed within 30 days of admission & prescribed by a LHSP** Y N

Date Completed _____. New Admission Y N
Name and credentials of LHSP _____
Document(s) maintained as evidence of ITP _____

3. **Written, dated & signed Treatment Plan Updates assessing the resident's progress in response to treatment. Completed at least every 3 months & signed by the case manager** Y N

Date Completed _____. New Admission Y N
Name and credentials of Staff _____
Document(s) maintained as evidence of Treatment Plan Updates _____
(Please note the last 6 Treatment Plan dates) _____, _____, _____, _____, _____, _____.

4. **Does the Plan of Care/TSP include a statement regarding the client's functioning level?** Y N

5. **Does the Plan of Care/TSP include a statement regarding the services necessary to meet the client's needs?** Y N

6. **Does the Plan of Care/TSP identify specific goals as related to the child's treatment or services?** Y N

7. **Does the Plan of Care/TSP contain information regarding the amount, duration, and scope of services/** Y N

8. **Does the Plan of Care/TSP identify who is responsible for providing the services?** Y N

Comments

_____

_____

_____

_____ _____

REVIEWER'S SIGNATURE **DATE**

_____

Reviewer's Name **(please print)**