2000-0082

INTRODUCED BY: ALBERT LAQUE, PARISH PRESIDENT
DEPARTMENT OF COMMUNITY SERVICES

ORDINANCE NO. 00-2-5

An ordinance to approve and authorize the Execution of an Agreement with the Department of Health & Hospitals to interview potential Medicaid clients.

WHEREAS, the Department of Community Services has applied for approval from the Department of Health and Hospitals to interview potential Medicaid clients and complete applicable applications; and,

WHEREAS, in order to operate this program it is necessary that an Agreement be executed.

THE ST. CHARLES PARISH COUNCIL HEREBY ORDAINS:

SECTION I. That the Agreement between the State of Louisiana, Department of Health and Hospitals, Bureau of Health Services Financing, and the St. Charles Parish Department of Community Services is hereby approved.

SECTION II. That the Parish President is hereby authorized to execute said Agreement on behalf of St. Charles Parish Department of Community Services.

NOW, THEREFORE BE IT ORDAINED, THAT WE, THE MEMBERS OF THE ST. CHARLES PARISH COUNCIL, do hereby approve and authorize the execution of and Agreement with the Department of Health & Hospital to interview potential Medicaid clients.

The foregoing ordinance having been submitted to a vote, the vote thereon was as follows:

YEAS: RAMCHANDRAN, FAUCHEUX, HILAIRE, FABRE, ABADIE, AUTHEMENT, BLACK, MARINO
NAYS: NONE
ABSENT: MINNICH

And the ordinance was declared adopted this 21st day of February, 2000, to become effective five (5) days after publication in the Official Journal.

CHAIRMAN: _____
SECRETARY: _____
DLVD/PARISH PRESIDENT: 2-22-00
APPROVED: ✓ DISAPPROVED: _____

PARISH PRESIDENT: _____
RETD/SECRETARY: 2-22-00
AT: 2:30 P.M. RECD BY: _____

LOUISIANA'S MEDICAID PROGRAM
APPLICATION CENTER CONTRACTUAL AGREEMENT

I. Identifying Information

Assigned Application Center Number	Type Facility	Application Center Name
03 - 05 - 0095	05	ST. CHARLES PARISH DEPARTMENT OF COMMUNITY SERVICES

Mailing Address			Street Address (Geographical Address)			
P. O. BOX 169			14564 RIVER ROAD			
City	State	Zip Code	City	State	Zip Code	Parish
NEW SARPY,	LA	70078	NEW SARPY	LA	70078	ST. CHARLES

Contact Person	Telephone Number	FAX Telephone Number	Federal Tax ID# or Social Security #
BARBARA DORSEY	(504) 764-7944	(504) 764-7943	72-6001208

II. Control of Facility

- ☐ Public - State Agency
- ☒ Public - City Control
- ☐ Partnership
- ☐ Charitable or Religious Organization
- ☐ Privately Owned
- ☐ Corporation

III. Type Client to be Served for Medicaid Applications (Check all that apply)

- ☐ New
- ☐ Change
- ☒ Current Clientele
- ☐ Public/Walk-Ins

IV. Notice

The Department of Health & Hospitals has assured compliance with the Department of Health & Human Services regulations promulgated under Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, as amended, which require that: **No person in the U. S. shall, on the grounds of race, color, religion, sex, national origin, or handicap be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance.**

Under these requirements, payment cannot be made for care and services under federally assisted programs conducted by the Bureau of Health Services Financing unless such care and services are provided without discrimination on the grounds of race, color, religion, sex, national origin, or handicap. Written complaints of non-compliance should be made to the Secretary of the Department of Health and Hospitals, P. O. Box 91030, Baton Rouge, Louisiana 70821-9030, or the Secretary of DHS, Washington, D. C., or both.

V. Signature

Signature of Administrator/CEO

Date 2/28/00

VI. State Office Use Only

Signature of Medicaid of Louisiana Representative

Date

VII. Administrator/CEO Confidentiality Statement

I, _____, understand my organization as a designated state approved Application Center must adhere to the
Administrator/CEO
following regulations regarding confidentiality responsibilities.

Federal Regulations 42 CFR 431.300 restricts the use or disclosure of information concerning applicants/recipients to purposes directly connected with the administration of Medicaid. Purposes directly related to Medicaid include:

- Establishing Medicaid eligibility and determining the type and amount of medical assistance.

Confidential information includes, at a minimum, the following:

Name and address of applicant/recipient, medical services provided, social and economic conditions or circumstances, evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.

It shall be unlawful for any person to solicit, disclose, receive, make use of, or to authorize, knowingly permit, participate in, or acquiesce in the use of applications or client information or the information contained therein for any purpose not directly connected with the administration of the Medicaid Program. Publications of Lists of names of applicants/recipients is prohibited.

Any person who violates any provisions of confidentiality is subject to a fine not more than two thousand five hundred dollars ($2,500) or imprisonment for not more than two years in the parish jail or both, nor less than five hundred dollars ($500) or ninety days on each count. In addition to these criminal penalties violation of confidentiality requirements shall result in the termination of certification to complete Medicaid applications.

I acknowledge that staff will adhere to all confidentiality provisions set forth by this agreement.

Rebel Howard
Signature of Application Center Administrator/CEO

3/2/2000
Date

VIII. Agreements and Responsibilities

I do hereby agree to adhere to published regulations of the Secretary and DHH/BHSF. I agree to any rules governing my participation as an Application Center.

I understand that I have the right to terminate this agreement for any reason in writing with thirty days advance notice to DHH. I understand that DHH has the right to terminate this agreement with ten days notice for violation of any of the stated agreements and responsibilities as set forth in this agreement.

I hereby agree to keep such records as are identified in the Application Center Handbook to disclose fully the extent of services provided to Medicaid individuals. I agree to maintain information regarding such records and regarding any payments claimed for providing such services that Louisiana's Medicaid Agency, the DHH Secretary, the Medicaid Fraud Control Unit, or the U.S. Department of Health and Hospitals may request for three years from the date of service.

I understand that to qualify for certification training, employees must agree to be bound by Federal and State requirements on client confidentiality, non-discrimination, and quality standards. I agree to sign the above confidentiality statement on behalf of my facility.

I agree to periodic monitoring by State officials without prior notice given. I further agree that State officials will have access to the premises to inspect and evaluate work being performed and to audit compliance with the Application Center agreement requirements. I understand that decertification may result if non-compliance with policy is found.

I agree that only persons who have successfully completed certification training with a passing grade will be allowed to take Medicaid Applications and agree to any additional follow-up training. I agree that any changes in certified staff will be reported to DHH within ten (10) calendar days and recorded in the facility's AC profile. I further agree to maintain training certificates and letter of regret on file and understand that each certified representative is required to take a minimum of two applications per month to remain certified with the exception of LTC facilities.

I understand that the Medicaid Application Center Handbook will be furnished to my facility (replacement or additional manuals must be purchased).

I understand that all copies of handbooks must be maintained and updated by a representative of my facility as revisions to policy and forms are issued.

I understand that application packets to be used will be distributed by the DHH Office which will maintain a record of quantities issued to each Center. It is the responsibility of my facility to maintain an Applications Transmittal log of applications taken for approval, monitoring, and review purposes. In the event this agreement is terminated by either party, I am responsible for returning all unused application packets within ten days of the termination of the agreement.

I understand that all Medicaid Application interviews must be scheduled and completed within (5) five working days from first day of request and I understand that all completed Medicaid Applications must be sent within (3) three working days from interview date to the Parish Medicaid Office.

Rebel Howard
Signature of Application Center Administrator/CEO

3/2/2000
Date