# Table of Contents

- **Overview**  
  - 3
- **Compliance with Sarbanes-Oxley Act**  
  - 5
- **Fraud and Abuse Prevention and Detection**  
  - 7
- **Whistle-blower Policy**  
  - 11
- **Records Retention Policy**  
  - 14
- **Chart of Accounts**  
  - 18
- **Budget Development**  
  - 19
- **Budget Monitoring and Financial Analysis**  
  - 20
- **Waitlist Management**  
  - 21
- **Vendor (Subcontractor) Selection**  
  - 23
- **PA Approval Process**  
  - 29
- **UCR Processing**  
  - 34
- **Signature Designees**  
  - 37
- **Readiness Fund**  
  - 39
- **Client Rep Payee Fund**  
  - 43
- **Debt**  
  - 44
- **Credit Cards**  
  - 46
- **Mail Distribution**  
  - 47
Purchasing

Financial Operations Policies & Practices

Accounts Payable
Payroll Processing
Employee Benefits Cost Accounting
Travel Reimbursements
Family Expense Reimbursements
Petty Cash Funds
Consumer Benefits
Billing and Accounts Receivable
Specialized (Non-Medicaid) Billing
Accounts Receivable Collections
Daily Deposits
Writing Off Outstanding Checks
Fixed Asset Acquisitions and Disposition
Journal Entries
Closing Procedures

Audit Practice

Exhibit A – Billing Instructions

Exhibit B – Chart of Accounts
Overview

One Sky Community Services, Inc. ("One Sky") is a private New Hampshire Nonprofit Corporation with an independent Board of Directors consisting of members of the community and family members of individuals served by One Sky.

One Sky is a non-profit organization incorporated as a 501(c)(3) organization and is registered with the Secretary of State in New Hampshire with a fiscal year end of June 30. The articles of incorporation state that the purpose of One Sky shall include:

- To plan, fund, provide and oversee community-based services and supports for children and adults with developmental disabilities and acquired brain disorders, to live as valued and participating members in their communities, and

In accordance with IRS Code section 501(c)(3) the One Sky is organized and operates exclusively for the exempt purpose as described in Form 1023, the application for exemption. In compliance with the restrictions on organizations qualifying under the 501(c)3 code:

- No part of the net earnings of the organization may inure to the benefit of any private shareholder or individual.
- No substantial part of the activities of the organization may consist of the carrying on of propaganda or of attempting to influence legislation (lobbying).
- The organization may not participate in, or intervene in, any political campaign on behalf of any candidate for public office.

One Sky is organized as a public charity under Section 170(b)(1)(A)(vi) of the Internal Revenue Code as an organization that normally receives:

- a substantial part of its support from a governmental unit or from the general public.
- more than 1/3 of its support from contributions, membership fees, and gross receipts from activities related to its charitable, etc. functions.

One Sky has a contract with the State of New Hampshire wherein One Sky acts as the designate area agency for Region 8 in the State of New Hampshire’s system to provide supports and services to individuals with developmental disabilities and acquired brain disorders.

One Sky prepares monthly unaudited financial statements for Board of Directors approval. Those unaudited monthly financial statements must also be submitted to the New Hampshire Bureau of Developmental Services no later than 30 days after the end of each month. Annual audited financials are required per contract with New Hampshire Bureau of Development Services (BDS), lending requirements, and support grant applications.

Annually, as part of the audit process, One Sky reviews these policies and practice statements and revises them, as necessary. After any revisions, staff are re-oriented to the changes in policy and practice.
The Chief Financial Officer (CFO) of One Sky is responsible for the preparation of financial information for both Board and staff review. This includes annual budgets, profit and loss statements, analysis, and any special reports that are requested. Financial matters are reviewed by the Finance Committee of the Board of Directors and the full Boards of Directors. Any major financial decisions are reviewed by the Finance Committee and voted on by the Board of Directors. Financial information is discussed at the Senior Leadership Team meetings and, by each senior manager with her/his staff.

Upon termination of employment, immediate action will be taken to remove or restrict the person’s access to the financial system.
Compliance with the Sarbanes-Oxley Act

The Sarbanes-Oxley (SOX) Act subjects public companies in the United States to additional governance and other requirements. While One Sky as a nonprofit is only required to comply with two provisions of the SOX Act, the Board has voted to voluntarily implement key provisions of the legislation.

1. One member of the finance committee should meet the criteria of financial expert and have adequate financial knowledge to understand, analyze, and reasonably assess the financial statements and the competency of the auditing firm.

2. The One Sky Finance Committee will meet with the auditor and review the annual audit. The Committee will recommend that the annual audit be accepted by the full board.

3. The Form 990 for One Sky will be reviewed and approved by the Finance Committee and the full Board. The Form will be made freely available to anyone who requests it.

4. One Sky will bid out auditing services every five years. The One Sky Finance Committee will oversee the bidding process and recommend a new auditing firm to the Board for their approval.

5. The auditing firm should not provide non-auditing services while the firm is contracted to provide auditing services. Tax preparation is the one exception to the rule.

6. The auditing firm will report all “critical accounting policies and practices that are used by the organizations, discussed with management, and represent the preferred way management wants these policies and practices treated. These critical accounting practices include methods, assumptions, and judgments underlying the preparation of financial statements according to generally accepted accounting principles (GAAP) and assurance that any results would be disclosed in case of changed assumptions.

7. The One Sky CEO and CFO will certify for all audited financial statements the following:
   A. They have reviewed the report for appropriateness.
   B. The report does not contain any untrue statements or a material fact or a material omission.
   C. The financials fairly present the financial condition of the organization.
   D. They have designed and evaluated systems of internal controls to make sure that they are aware of material information concerning the organizations operations.
   E. They have disclosed to the auditors and finance committee deficiencies in the controls as well as any fraud involving management or other key employees.

8. One Sky implemented the listed best practices:
   A. Compliance with all practices and procedures in the Board of Director by-laws
   B. A CEO Performance and Compensation policy.
C. A Sole Source Justification policy.
D. A policy for Contract Purchases over $50,000.
E. A Vendor (Subcontractor) Selection policy.

9. One Sky currently has a document destruction and retention policy that has been updated to include the following:
   A. One Sky staff and volunteers will be aware that it is a crime to destroy, alter, cover up, or falsify any document (or persuade someone else to do so) to prevent its use in an official proceeding (litigation, federal investigation, bankruptcy proceeding, etc.)
   B. If an official investigation is underway or suspected, management must stop any document destruction in order to avoid criminal obstruction charges.
   C. Guidelines will be established for handling electronic files and voicemail, which have the same status under the SOX Act as paper files in litigation-related cases.
Purpose and Scope

One Sky Community Services, Inc. is dedicated to conducting Finance and Accounting in an ethical and legal manner. If fraudulent behavior is minimized, the risk of scarce resources being diverted from appropriate use in providing One Sky services to the public will be significantly reduced. One Sky, its officers, contractors, agents, and employees will comply with all relevant federal and state laws and regulations related to billing and coding. No One Sky staff has the authority to direct, participate in, approve, or tolerate any violation of any of the laws described in this policy.

Focus Area: All One Sky Community Services

Policy

One Sky will thoroughly and quickly investigate any reported cases of suspected fraud to determine if disciplinary, financial recovery, and/or criminal action should be taken. All reports of suspected fraud will be handled under the strictest confidentiality. One Sky recognizes the need to continually update standards and procedures and to communicate these changes to employees, contractors, and agents to keep them informed regarding One Sky’ operations. We are committed to the following efforts:

1. Minimize billing mistakes
2. Increase speed and optimize receipt of claim payments
3. Reduce chance of Office of Inspector General or Centers for Medicare & Medicaid Services (CMS) audit, or audits from external funding sources
4. Avoid conflicts with self-referral and anti-kickback and other statutes.

Set forth below are summaries of certain laws that provide liability for false claims and statements. These summaries are not intended to identify all applicable laws; but serve to outline some of the major statutory provisions.

Federal Laws

Federal Civil False Claims Act (FCA); 31 U.S.C. §§ 3379-3733

Congress enacted the federal civil False Claims Act in 1982. The Act is designed to enhance the government’s ability to identify and recover losses due to fraud.

Prohibitions
The federal civil False Claims Act makes it a crime for any person or organization to knowingly make a false record of file a false claim with the federal government (Medicare, Medicaid) for payment.

“Knowingly” means

1. Having actual knowledge of the information;
2. Acting in deliberate ignorance of the truth or falsity of the information; or
3. Acting in reckless disregard for whether the information is true or false. Specific intent to defraud is not required for there to be a violation of the law.

The False Claims Act is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years after a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed.

**Penalties**

A person or entity found to have violated the civil False Claims Act is subject to a civil money penalty of not less than $5,500 and not more than $11,000, plus three times the amount of damages the federal government sustained.

**Qui Tam and Whistleblower Protection Provisions**

The U.S. False Claims Act authorizes the U.S. Attorney General to bring legal actions alleging violations of the statute. The statute also allows private citizens to file a lawsuit in the name of the United States for false or fraudulent claims submitted by individuals or companies that do Finance and Accounting with, or are reimbursed by, the United States (Medicare, Medicaid). Commonly known as a qui tam action, a lawsuit brought under the Act by a private citizen begins with the filing of a civil complaint in federal court.

As an incentive to bring these cases, the law provides that whistleblowers who file a qui tam action may receive a percentage of the money recouped as a reward. This reward may be reduced, however, if for example the court finds the whistleblower planned and initiated the violation. The act also provides that “whistleblowers” that prosecute clearly frivolous qui tam claims can be held liable to a defendant for its attorneys’ fees and costs.

Whistleblowers are given certain protections under the Act from retaliation, such as being discharged, demoted, or harassed, for bringing an action under the law.

**The Program Fraud Civil Remedies Act of 1986**
The Program Fraud Civil Remedies Act of 1986 (PFCRA) authorizes federal agencies to investigate and assess penalties for false claims to certain federal agencies, including the Department of Health and Human Services. PFCRA was enacted as a means to address lower dollar frauds, and generally applies to claims of $150,000 or less.

Penalties: A person or entity found to have violated the PFCRA is subject to a civil money penalty of up to $5,000 per false claim and up to twice the amount claimed.

**New Hampshire False Claims Laws**

NH RSA 167:61-b states that any person or provider shall be liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 plus 3 times the amount of damages that the state sustains because of the act of knowingly making a statement to get a false or fraudulent claim paid or approved, or knowingly making a false record or statement to conceal, avoid, or decrease an obligation to pay.

Also liable is any beneficiary of an inadvertent submission of a false claim who subsequently discovers the falsity of the claim, and fails to disclose this within a reasonable time after discovery of the false claim.

**Administrative Remedies for False Claims (Title 31 U.S.C. Chapter 38. §§3801-3812)**

This federal statute allows for administrative recoveries by federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information or omits material information. One Sky, receiving the claim, may impose a monetary penalty of up to $5,000 per claim and damages of twice the amount of the original claim. Unlike the False Claims Act, a violation of the law (Title 31 U.S.C. Chapter 38. §§3801-3812) occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and imposition of fines and penalties is made by One Sky and not by prosecution in the federal court system.

**New Hampshire Whistleblower Protection Act**

NH RSA 275-E:2 protects employees reporting violations, and guarantees that no employer shall discharge, threaten, or discriminate against any employee because the employee, in good faith, reports verbally or in writing, what the employee has reasonable cause to believe is a violation of a state rule or state or federal law.

The employee should first bring the alleged violation to the attention of a supervisor, and then allow the employer a reasonable opportunity to correct that violation, unless the employee had specific reason to believe that reporting the violation to his employer would not result in a prompt remedy.
PROCEDURES

One Sky supports these efforts through the following internal compliance procedures:

1. As policies and procedures are updated, these changes will be communicated to employees, contractors, and agents to keep them informed regarding One Sky’s operations.

2. One Sky will require:
   a. Periodic internal audits that monitor and correct performance/productivity issues
   b. Progressive training to educate/reinforce a compliant culture
   c. Recognition and reporting of deviations through the facilitation of open lines of communication, and
   d. Enforcement of standards through well-publicized guidelines

3. One Sky will:
   a. Promptly repay any overpayments which it discovers
   b. Establish a reserve account to hold any disputed funds until the results of an internal investigation determine whether the money is an overpayment to be repaid or whether it was properly paid and should be returned to the general fund

4. One Sky’s employees, contractors, and agents shall retain all records for six years.

5. Any suspected incidents of non-compliance shall be reported to the One Sky Director of Quality Improvement and the One Sky Program Director of the department where such suspected non-compliance is occurring, for review and action. All incidents of non-compliance will be reported to the One Sky CEO, the Chief Financial Officer, and to the Director of HR and Administration.

6. All contracts and other arrangements with providers, referral sources, and other persons may be reviewed by One Sky’s outside counsel to verify legal compliance

7. Disciplinary action, in accordance with the Employee Discipline policy, will be taken against employees who authorize or participate directly in a violation of applicable state or federal law, or these policies and procedures, and any employee who may have deliberately failed to report such a violation, or who hinders an investigation.

8. After review by Senior Management and as appropriate, One Sky will contact the Medicaid Fraud Control unit to investigate reported irregularities.

   Medicaid Fraud Control Unit
   Office of the Attorney General
   33 Capital Street
   Concord, NH 03301
   Telephone: (603) 271-1246
   Fax: (603) 223-6274
Whistle-blower Policy

One Sky Community Services, Inc. complies with the State of NH Whistleblower Protection Act RSA 275-E

Purpose and Scope  Section 407  Whistleblower Protection

Focus Area:  All One Sky Community Services

Policy

One Sky encourages staff to bring instances of improper conduct to the attention of someone who can be counted on to investigate the problem promptly and fairly, without any fear of retaliation. It is illegal for One Sky or any company to punish a whistle-blower in any manner. Sarbanes-Oxley Act has encouraged One Sky to implement and enforce a whistle-blower policy.

One Sky Community Services, Inc. complies with the State of NH Whistleblower Protection Act RSA 275-E.

The following policy has been adopted to maintain the highest standards of conduct and ethics and comply with applicable laws and regulations.

1. Any suspected fraudulent or dishonest use or misuse of resources or property by staff, board members, consultants, or volunteers will be investigated.
2. All individuals including staff, board members, consultants and volunteers, connected with this organization are encouraged to report suspected fraudulent or dishonest conduct, including but not limited to waste, financial or other impropriety or abuse, to the attention of a responsible person who can be counted on to investigate the problem promptly and fairly. In other words, in these circumstances, all individuals are called on to act as “whistleblowers”.
3. Any staff member, board member, consultant or volunteer who reports waste, fraud, financial or other impropriety or abuse will not be fired or otherwise retaliated against for making the report. Even if the matter is determined not to constitute improper conduct, the individual making the report will not be retaliated against. Further, that person will not be subject to any punishment – including firing, demotion, suspension, reprimand, harassment, failure to be considered for promotion, or any other kind of discrimination – in retaliation for making the report.

One Sky will adhere to the following guidelines in order to maintain “best practices”:

1. One Sky will establish a confidential and anonymous mechanism to encourage employees to report any inappropriateness by One Sky financial management or other complaints.
2. No punishment for reporting issues will be allowed. Even if the claims are unfounded; a reasonable belief or suspicion that fraud exists is enough to create a protected status for the employee.

3. Management and the Board will take every employee complaint seriously; investigate; correct any problems or justify why corrections are not necessary.

4. All employee reports will be kept completely confidential. No information likely to reveal your identity will be shared with anyone else without your permission. Staff will be completely protected from retaliation for having made good faith reports.

5. One Sky will eliminate careless and irresponsible accounting practices should any be discovered.

6. One Sky may initiate an internal audit to identify weak areas and create processes that are not vulnerable to fraud and abuse.

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3. Any staff member, board member, consultant or volunteer who reports waste, fraud, financial or other impropriety or abuse will not be fired or otherwise retaliated against for making the report. Even if the matter is determined not to constitute improper conduct, the individual making the report will not be retaliated against. Further, that person will not be subject to any punishment – including firing, demotion, suspension, reprimand, harassment, failure to be considered for promotion, or any other kind of discrimination – in retaliation for making the report.

Procedure

1. The report of suspected waste, fraud, or abuse can be made the following ways and anonymously, if so desired. Send a written report, email or telephone call to, or request a personal meeting with:
   • CEO – One Sky Community Services
   • Director of HR and Administration
   • President of the Board of Directors.

2. The report will be taken seriously and investigated.
The CEO, Director of HR and Administration or Executive Committee of the Board of Directors will review the facts of the complaint.

The CEO, Director of HR and Administration or Executive Committee of the Board of Directors will investigate or enlist an appropriate person to investigate.

3. The CEO, Director of HR and Administration or Executive Committee of the Board of Directors will provide feedback to the employee regarding a correction or justify why no correction is warranted.
   a. The person or persons charged with alleged impropriety will be given an opportunity to respond to the allegations in person or in writing.

4. Following the investigation, this organization will:
   a. Provide the person filing the report with a summary of the findings;
   b. Take appropriate steps to deal with the issue addressed, including making operational or personnel changes, or justify why corrections are not necessary;
   c. If warranted, contact law enforcement to deal with any suspected criminal activities.
   d. All founded complaints and any actions taken by the CEO, Board Chair or recommended by the investigation will be presented to the full board.

5. This organization will maintain confidential records of all actions taken under this Policy.

6. The CEO has responsibility for compliance with this Policy.

7. The Board of Directors Executive Committee has responsibility for oversight of compliance with this Policy.
Records Retention

Focus Area: All One Sky Community Services - All records: Programmatic, clinical and financial, will be maintained a minimum of ten years.

If records required by State of NHRSA or Administrative Rule Regulations; outside of stating operational policy, One Sky Community Services, Inc. will adhere to that standard.

Policy

This policy covers all records and documents, regardless of physical form, contains guidelines for how long certain documents should be kept and how records should be destroyed. The policy is designed to ensure compliance with federal and state laws and regulations, to eliminate accidental or innocent destruction of records and to facilitate the operation of the One Sky Community Services by promoting efficiency and freeing up valuable storage space.

One Sky Community Services retention schedule is set forth in below. The Director of HR and Administration (“Administrator”) shall administer this Policy. The Administrator is also authorized to make modifications to the Record Retention Schedule from time to time to ensure that it is in compliance with local, state and federal laws and included the appropriate document and record categories for the organization; monitor local, state and federal laws affecting record retention; annually review the record retention and disposal program; and monitor compliance with this policy.

Electronic documents will be retained as if they were paper documents. Therefore, any electronic files that fall into one of the document types in Appendix A will be maintained or the appropriate amount of time. If an employee has sufficient reason to keep an email message, the message should be printed in hard copy and kept in the appropriate file or maintained to an “archive” computer file.

No officer, director, employee, volunteer or agent of One Sky Community Services shall destroy, dispose of, conceal or alter any record or document while knowing that is or may be relevant to an anticipated or ongoing investigation or legal proceedings conducted by or before a federal, state or local government agency, including tax and regulatory agencies, law enforcement agencies, and civil and criminal courts or an anticipated or ongoing internal investigation, audit or review conducted by One Sky Community Services.

During the occurrence of an anticipated or ongoing investigation or legal proceeding as set forth above, the Administrator shall suspend any further disposal of documents until such time as the Administrator, with the advice of counsel, determines otherwise. The Administrator shall take such steps as necessary to promptly inform all staff of any suspension in the further disposal of documents.
Record Retention Schedule

A. Program and Service Records

Program and Services Records follow retention periods stated within HIPAA Guidelines (Will follow HIPAA Guidelines which are more stringent than the State of New Hampshire Regulations-at minimum 10 years)

<table>
<thead>
<tr>
<th>Program and Services</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Services</td>
<td>He-M 502</td>
</tr>
<tr>
<td>Services for the Developmentally Disabled</td>
<td>RSA 171A</td>
</tr>
<tr>
<td>Intake (Eligibility)</td>
<td>He-M 503 and He-M 522</td>
</tr>
<tr>
<td>Early Supports and Services</td>
<td>He-M 510, He-M 203</td>
</tr>
<tr>
<td>Family Support Respite Services</td>
<td>He-M 513</td>
</tr>
<tr>
<td>Family Support Services</td>
<td>He-M 519</td>
</tr>
<tr>
<td>Family Support In-Home Supports</td>
<td>He-M 524</td>
</tr>
<tr>
<td>Family Support Advisory Council</td>
<td>He-M 513.06</td>
</tr>
<tr>
<td>Waitlist and Funding Allocation</td>
<td>He-M 503.14</td>
</tr>
<tr>
<td>Participant Directed and Managed Services</td>
<td>He-M 525</td>
</tr>
<tr>
<td>Certification of Residential Services or Combined Residential &amp; Day Services Provided in the Family Home</td>
<td>He-M 521</td>
</tr>
<tr>
<td>Adult Service Coordination</td>
<td>RSA 171B, He-M 202, He-M 503, He-M 521</td>
</tr>
<tr>
<td>Community Participation Services</td>
<td>He-M 507</td>
</tr>
<tr>
<td>Certified Community Residences</td>
<td>He-M 1001</td>
</tr>
</tbody>
</table>

B. Accounting and Finance

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable ledges &amp; schedules</td>
<td>7 years</td>
</tr>
<tr>
<td>Accounts Receivable ledgers &amp; schedules</td>
<td>7 years</td>
</tr>
<tr>
<td>Audit Reports and Financial Statements</td>
<td>7 years</td>
</tr>
<tr>
<td>Annual Audit Records (including papers &amp; other documents that relate to the audit)</td>
<td>7 years after completion of audit</td>
</tr>
<tr>
<td>Expense Records</td>
<td>7 years</td>
</tr>
<tr>
<td>General ledgers</td>
<td>Permanent</td>
</tr>
<tr>
<td>Electronic Payment Records</td>
<td>7 years</td>
</tr>
<tr>
<td>Notes Receivable ledges &amp; schedules</td>
<td>7 years</td>
</tr>
<tr>
<td>Investment Records</td>
<td>7 years after sale of investment</td>
</tr>
</tbody>
</table>
### C. Corporate Records

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Reports to Secretary of State/Attorney General</td>
<td>Permanent</td>
</tr>
<tr>
<td>Articles of Incorporation &amp; By-Laws</td>
<td>Permanent</td>
</tr>
<tr>
<td>Board Meeting &amp; Board Committee Minutes</td>
<td>Permanent</td>
</tr>
<tr>
<td>Board Policies/Resolutions</td>
<td>Permanent</td>
</tr>
<tr>
<td>IRS Application for Tax-exempt Status</td>
<td>Permanent</td>
</tr>
<tr>
<td>IRS Determination Letter</td>
<td>Permanent</td>
</tr>
</tbody>
</table>

### D. Employee Documents

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Plans</td>
<td>Termination + 7 years</td>
</tr>
<tr>
<td>Employee Files</td>
<td>Termination + 7 years</td>
</tr>
<tr>
<td>Forms I-9</td>
<td>3 years after hiring, or 1 year after separation</td>
</tr>
<tr>
<td>Employment Taxes</td>
<td>7 years</td>
</tr>
<tr>
<td>Payroll Registers (gross &amp; net)</td>
<td>7 years</td>
</tr>
<tr>
<td>Time cards/Sheets</td>
<td>7 years</td>
</tr>
<tr>
<td>Unclaimed Wage Records</td>
<td>6 years</td>
</tr>
</tbody>
</table>

### E. Property Records

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lease Agreement</td>
<td>Permanent</td>
</tr>
<tr>
<td>Property Insurance Policies</td>
<td>Permanent</td>
</tr>
</tbody>
</table>

### F. Tax Records

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax-Exemption Documents &amp; Related Correspondence</td>
<td>Permanent</td>
</tr>
<tr>
<td>IRS 990 and 990T tax returns</td>
<td>Permanent</td>
</tr>
<tr>
<td>Tax Bills, Receipts, &amp; Statements</td>
<td>7 years</td>
</tr>
<tr>
<td>Tax Work paper Packages – Originals</td>
<td>7 years</td>
</tr>
</tbody>
</table>
### G. Grant Records

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original grant proposal</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>Grant agreement &amp; subsequent modifications if applicable</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>All requested IRS/grantee correspondence including determination letters &amp;</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>“no change” in exempt status letters</td>
<td></td>
</tr>
<tr>
<td>Final grantee reports, both financial and narrative</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>All evidence of returned grant funds</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>All pertinent formal correspondence including opinion letters of counsel</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>Report assessment forms</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>Documentation relating to grantee evidence of invoices and matching or</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>challenge grants that would support grantee compliance with grant agreement</td>
<td></td>
</tr>
<tr>
<td>Pre-grant inquiry forms and other documentation for expenditure responsibility</td>
<td>7 years after completion of grant period</td>
</tr>
<tr>
<td>grants</td>
<td></td>
</tr>
<tr>
<td>Grantee work product produced with the grant funds</td>
<td>7 years after completion of grant period</td>
</tr>
</tbody>
</table>
# Chart of Accounts

**Focus Area:** All One Sky Community Services

<table>
<thead>
<tr>
<th>Assets</th>
<th>Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1####</td>
<td>4####</td>
</tr>
<tr>
<td>Cash Accounts</td>
<td>Rental Revenue</td>
</tr>
<tr>
<td>10###</td>
<td>40###</td>
</tr>
<tr>
<td>Receivable Accounts</td>
<td>Contributed Revenue</td>
</tr>
<tr>
<td>11###</td>
<td>41###</td>
</tr>
<tr>
<td>Prepaid Accounts</td>
<td>Program Revenue</td>
</tr>
<tr>
<td>12###</td>
<td>42###</td>
</tr>
<tr>
<td>Land &amp; Building</td>
<td>Other Revenue</td>
</tr>
<tr>
<td>15###</td>
<td>43###</td>
</tr>
<tr>
<td>Furniture &amp; Equipment</td>
<td></td>
</tr>
<tr>
<td>16###</td>
<td></td>
</tr>
<tr>
<td>Other Assets</td>
<td></td>
</tr>
<tr>
<td>18###</td>
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</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Expenses</th>
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<tr>
<td>2####</td>
<td>6####</td>
</tr>
<tr>
<td>Current Accounts Payable</td>
<td>Personnel Expenses</td>
</tr>
<tr>
<td>20###</td>
<td>60###</td>
</tr>
<tr>
<td>Accrued Payroll &amp; Payroll</td>
<td>Office Expenses</td>
</tr>
<tr>
<td></td>
<td>61###</td>
</tr>
<tr>
<td>Taxes Payable</td>
<td>Building Expenses</td>
</tr>
<tr>
<td>21###</td>
<td>62###</td>
</tr>
<tr>
<td>Accrued Liabilities</td>
<td>*repairs &amp; maintenance</td>
</tr>
<tr>
<td>23###</td>
<td></td>
</tr>
<tr>
<td>Deferred Revenue</td>
<td>*garbage &amp; snow removal</td>
</tr>
<tr>
<td>24###</td>
<td></td>
</tr>
<tr>
<td>Mortgages and Notes Payable</td>
<td>*equipment expenses</td>
</tr>
<tr>
<td>25###</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net Assets</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3####</td>
<td></td>
</tr>
</tbody>
</table>

See Exhibit B for Current Active Chart of Accounts
Budget Development

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

Annually, budgets shall be developed and submitted to the Board for their approval. The major funder of services (NH Department of Health & Human Services) for One Sky requires the submission of annual budgets. These budgets are part of the contracting process and the due dates for submission are determined by the individual funder.

Once due dates are known, the CFO creates a timeline and process for One Sky’s budgets to meet the funder’s due dates. The budget timeline and process is reviewed with senior management, the Board, and staff preparing budget information for their input. The CFO is responsible for the development of the One SKY annual budget based on the information provided by the Senior Leadership Team.

Once the budget for One Sky is developed, the CFO reviews it with the CEO. Any modifications are made prior to discussing it with the Finance Committee. The budget is then presented to the full board for approval. Once the budget has been approved by the Board, it is submitted to the funder.
Budget Monitoring and Financial Analysis

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

The CFO is responsible for the development of monthly and annual profit and loss statements, financial analysis, and any special reports that are requested or needed. This information is distributed to:

- CEO
- Senior Leadership Team
- Finance Committee

The CEO and Senior Leadership Team will annually develop benchmarks for budget performance. These benchmarks will include both the amount a budget (revenue or expenses) may be over or under projections and the length of time for these differences before triggering further analysis or action. This information will be shared with the Finance Committee.

While the CFO prepares overall financial reports for One Sky the CEO and senior managers also do their own analysis. Senior managers are responsible for their budgets, including revenues and expenses. If additional analysis is needed, the CFO may be asked to produce the additional information.

Financial information, including budgets, profit and loss statements, and any analysis are a standing agenda item for the Senior Leadership Team. This discussion will include, but is not limited to, common financial information such as Medicaid billing analysis and year-end forecasts. Any follow-up needed will be assigned during Senior Leadership Team and the results discussed at the next team meeting or shared via email. In addition to the Senior Leadership Team, financial information is distributed to key managers, as identified by the Senior Leadership Team.

Financial accountability is a part of the performance appraisal for the CEO, members of the Senior Leadership Team, and any other staff who have this as part of their responsibility.

The CFO will prepare and distribute financial information three days prior to the Finance Committee meeting. Under its contract with the State of New Hampshire One Sky is required to submit monthly financial results within 30 days of month end. Since the One Sky Board of Directors meetings take place on the second Tuesday of each month, Finance Committee meetings will be scheduled to take place no later than the last Friday of the month preceding.

In the case of a delay in the meeting of the Finance Committee, the Finance and Accounting Department will submit Financial Statements to the State with the Note “Internal Results, not
reviewed or approved by One Sky Community Services, Inc.’s Finance Committee, Anticipated Completion Date 7/31/19, pending approval by Board of Directors”
**Waitlist Management**

**Focus Area:** All One Sky Community Services

**Referral Process**

The following process should be followed when requesting that an individual client be placed on the Wait List for Funding:

1. Service Coordinator identifies one of three conditions that a client may be eligible for inclusion in the Wait List process for funding:
   a. Individual will be turning 21 within the next fiscal year (July 1 – June 30)
   b. Individual client is new to services/area and requires services
   c. Client has/will experience a significant life/health impacting event
      i. Increase in severity of current physical/mental/emotional disability
      ii. Impending change in living situation (inability of current caretaker to provide level of required support/care)
      iii. Risk to self or others.
2. Service Coordinator verifies Medicaid eligibility.
3. If eligible, Service Coordinator completes the “Wait List Registry Referral Form” and submits form to Team Manager.
4. Team Manager reviews form and if complete and accurate, presents case to “Wait List Committee”.
5. Committee approves/disapproves of client addition to “Wait List”.
   a. If disapproved, Committee will provide explanation/guidance to Service Coordinator Team Manager to be communicated to Service Coordinator.
   b. If approved, Service Coordinator will start “Pre-Authorization” Packet paperwork process to ensure all required meetings/documentation/budgets will be created in support of client receiving services as funding becomes available.
   c. Service Coordinator updates Registry Referral Form to reflect PA Start Date.
6. Completed Registry Referral Form is forwarded to the Manager- Processes, Systems and Documentation who uses it to update the waitlist registry.
7. Client notified of status as appropriate by Service Coordinator.
### Wait List Registry Referral Form

<table>
<thead>
<tr>
<th>Service Coordinator:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client:</td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>NH Medicaid Number:</td>
<td></td>
</tr>
<tr>
<td>APTD Eligible:</td>
<td></td>
</tr>
<tr>
<td>Redetermination Date:</td>
<td></td>
</tr>
<tr>
<td>Wait List Category:</td>
<td></td>
</tr>
<tr>
<td>A. Person in school, eligible for services turning 21</td>
<td></td>
</tr>
<tr>
<td>B. Newly eligible adult</td>
<td></td>
</tr>
<tr>
<td>C. Existing client receiving services with significant life/medical changes</td>
<td></td>
</tr>
<tr>
<td>Required Services Start Date:</td>
<td></td>
</tr>
<tr>
<td>Required Packet Start Date:</td>
<td></td>
</tr>
<tr>
<td>If “C” category - nature of significant life/medical change</td>
<td></td>
</tr>
<tr>
<td>Projected Needs (age, status, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

**RSA 171A Diagnosis:** (check all that apply)

- Cognitive Disability / Intellectual Disability:
  - [ ] Mild
  - [ ] Moderate
  - [ ] Severe
  - [ ] Profound

  **and**

- Functional Disability:
  - [ ] CP
  - [ ] Seizure Disorder

**Specific Learning Disability**

- [ ] Autism

**Lives Where:**

- [ ] Independently
- [ ] With Family Member(s)
- [ ] Nursing Home
- [ ] Correction Agency
- [ ] Residential School
- [ ] NHH

**Consumer Significant Factors:** (check all that apply)

- [ ] Advanced Age
- [ ] Long Time on WL compared to others
- [ ] Declining Health
- [ ] In/at risk of institutional Placement
- [ ] Low Safety Awareness
- [ ] Regression Diminishing Independence
- [ ] Needs to Maintain Employment

**Family Factors:**

- [ ] Caregiver Advanced Age
- [ ] Caregiver Declining Health
- [ ] High Caregiver Work Demands
- [ ] Other Family Members Need Care
- [ ] Sole Caregiver-No other supports
- [ ] Living w/family w/o day services
**Community Safety: Choose 1**

- [ ] Forensic (established risk)
- [ ] Community Safety (potential risk)
- [ ] No Known Risk Potential

**Services – currently has, as well as needed:**

<table>
<thead>
<tr>
<th>Current Funding</th>
<th>Current Funding</th>
<th>Type of Service</th>
<th>Needed</th>
<th>Date Needed</th>
<th>Estimated Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>$</td>
<td>Choose Service Type</td>
<td>Choose Need</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Y</td>
<td>$</td>
<td>Choose Service Type</td>
<td>Choose Need</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Y</td>
<td>$</td>
<td>Choose Service Type</td>
<td>Choose Need</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

*Estimated cost from actual RFP or historical data

**Additional information not covered** above (less than 250 characters) i.e. Day Program Pairing (1:1, 2:1, 3:1):

**Other services currently in place:**

- [ ] FS Respite
- [ ] Mental Health Services
- [ ] Other Health/Medical Insurance
- [ ] Veterans Benefits
- [ ] Other: Explain

**Level of supervision required** (include any special considerations):

**Medical, behavioral or other assessment completed or recommended:**

<table>
<thead>
<tr>
<th>SIS Date:</th>
<th>HRST Date:</th>
<th>START Ref. Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIS Index:</th>
<th>Healthcare Level:</th>
<th>START Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIS %:</th>
<th>Total Score:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Assessments (completed, required or recommended):**

**SC Team Manager Signature:**

Signature indicates compliance with He-M 503.13 (3)(h) for Wait List Funding.

**Approved for Wait List:**

- [ ] YES
- [ ] NO

**COMMENTS FROM COMMITTEE:**
### Definition of Terms

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Start Date</td>
<td>Date service begins</td>
</tr>
<tr>
<td>BTS Funding</td>
<td>Current Approved Annualized (2nd Column) BTS Funding for Specific Service</td>
</tr>
<tr>
<td>Date Off List</td>
<td>Date Item is off Wait List</td>
</tr>
<tr>
<td>Date Services Needed</td>
<td>Date Individual needs Service</td>
</tr>
<tr>
<td>Initial Cost Estimate</td>
<td>Total cost for the service requested less the amount of current BTS funding already assigned for the specific service being requested</td>
</tr>
<tr>
<td>Notes</td>
<td>Notes about the particular service - this is separate and distinct from the Status Notes and Reason for Request</td>
</tr>
<tr>
<td>Projected Date</td>
<td>Area Agency's estimate of the start date</td>
</tr>
<tr>
<td>Reason Off List</td>
<td>Reason Consumer service no longer requested or needed</td>
</tr>
<tr>
<td>Service Requested</td>
<td>Specific Wait List Service Requested</td>
</tr>
<tr>
<td>Status</td>
<td>Status of Service Request</td>
</tr>
<tr>
<td>Total BTS Funding</td>
<td>Total amount of annualized funding listed for this individual, including funds for all types of services funded, as approved by the area agency's Regional Liaison as it appears in the Bureau's BTS program</td>
</tr>
<tr>
<td>Wait List Category A</td>
<td>Individuals in school and already eligible for services from the area agencies, funds shall be allocated within 90 days prior to the individual graduating with a regular high school diploma in accordance with the requirements of Ed 306.27, or exiting the school system at age 21, or earlier, so that any new or modified services needed are available and provided upon such school graduation or exit</td>
</tr>
<tr>
<td>Wait List Category B</td>
<td>Newly found eligible adults, the period between the time of completion of a basic service agreement and the allocation by the department of the funds needed to carry out the services required by the service agreement shall not exceed 90 days</td>
</tr>
<tr>
<td>Wait List Category C</td>
<td>Individuals already receiving services who experience significant life changes, the period of time for initiation of new services shall not exceed 90 days from the amendment of the service agreement except by mutual agreement between the area agency and the individual specifying a time limited extension.</td>
</tr>
<tr>
<td>WL Allocation</td>
<td>Annualized Funding amount actually assigned by BDS to the Client for the service requested</td>
</tr>
</tbody>
</table>
Vendor (Subcontractor) Selection

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

One Sky Community Services, Inc. supports participant choice in selection of vendor(s). Participants have options for vendor selection in the current Network (established vendors under master contract). There are also options within Consumer Directed Services to select out-of-network vendors. All choices must be approved by One Sky and depend on the availability of funds.

Existing Service Contracts

Options for day or employment services are different from options for residential services.

1. Day or Employment Fee for Service (FFS)

   The participant can change vendors under FFS vendors with two month’s notice where service rates are the same. The participant selects a new vendor. The CFO will notify the current vendor that a change will be made, giving the current vendor 60 days’ notice. Termination Notices shall be sent via certified mail, return receipt, to any one of the other party’s authorized representatives, and if without cause the thirty days shall be effective from the date the Notice is mailed, and if for cause, upon the date of mailing unless another date is specified.

2. Residential/Other Services

   The participant and/or Service Coordinator will examine the current budget. The participant, Service Coordinator, and other One Sky staff will discuss potential new vendors. When potential vendors have been identified, the budget will be requested. Following budget approval, the participant will select a new vendor. Changes at the same cost from vendors within the Network are generally approved with 60 days’ notice to all parties. Changes requiring additional revenue may not be approved.

3. Conversion to Consumer Directed Services

   The participant and/or Service Coordinator will examine the current budget. The participant, Service Coordinator, and other One Sky staff will discuss the request and make a referral to Consumer Directed Services. An initial meeting will be held with Consumer Directed Services staff to determine suitability for a self-directed option. There are budget limits (maximums) for this program. Changes at the same cost from
vendors within the Network to Consumer Directed Services are generally approved with 60 days’ notice to all parties.

New Services

Options for day or employment services are different from options for residential services. Any new proposal for services for Day or Employment Services requires a budget. All residential proposals require a budget and may require two or more bids. Total costs in excess of $100,000 per year are subject to additional review by One Sky.

1. **Day or Employment Fee for Service (FFS)**

   The participant will interview potential vendors and select a vendor. The Service Coordinator will notify One Sky administration and submit information for review. Choices are subject to the availability of funds and the capacity of the vendor to offer the requested services.

2. **Residential/Other Services**

   The Participant will work with the Service Coordinator to develop a profile for services to be used in an RFP process. The participant, Services Coordinator, and other One Sky staff will discuss potential new vendors. When potential vendors have been identified, the budget will be requested. The participant and One Sky will review proposals and identify their preferences. Final approval by One Sky will be based on cost and services proposed and require approval from the NH Bureau of Developmental Services.

3. **Consumer Directed Services**

   The participant asks for a referral to Consumer Directed Services. An initial meeting will be held with Consumer Directed Services staff to determine suitability for a self-directed option. If suitable, the participant works with Consumer Directed Services staff to develop a budget and Service Agreement. All requests are subject to the approvals of both One Sky and the NH Bureau of Developmental Services.

New Vendors

The following practices are used for reviewing requests by new vendors to deliver services under contract with One Sky Community Services or through a vendor agreement with a participant in Consumer Directed Services.

1. **Vendor Application**
The vendor contacts One Sky to inquire if applications are being accepted.

2. **Application Process**
   If applications are being accepted the Vendor is provided with instructions on submission of an application package.

3. **Interview**
   All potential vendors will be interviewed by One Sky.

4. **Decision**
   Following completion of the application and the interview, a decision will be made regarding accepting or rejecting the vendor as a Network Vendor or an Out-Of-Network Vendor (Consumer Directed Services only).
PA Approval Processing

Focus Area: One Sky Community Services, Finance and Accounting Department

The purpose of this procedure is to define the process to be used to request and obtain approval for Prior Authorization Requests that are needed to enroll/renew eligible individuals within the Community Care Waiver (CCW) System. This policy applies to all One Sky Community Services employees and covers all CCW waivered services including Developmental Disability (DD), In Home Supports (IHS) and Acquired Brain Disorders (ABD).

Policy

1. Prior to requesting, renewing or changing a CCW service the Service Coordinator will log into MMIS to verify that the individual is currently eligible for Medicaid. If not eligible, no request will be submitted until eligibility has been established.

2. After confirming the individual’s Medicaid eligibility the Service Coordinator will follow the Budget and Prior Authorization Checklist and pull together the relevant information (the “PA Approval Packet”) in preparation for the Department of Health and Human Services (DHHS) determination of CCW eligibility and prior authorization (“PA”) approval. Depending on the type of request (New Services, Annual Renewals, Changes), the information required may include the following:

   a. Medicaid ID#
   b. MMIS verification of Medicaid Eligibility
   c. Current Approved PA
   d. Proposed New Budget
   e. Description of Services Offered (the “Blurb”)
   f. Unit Change Request (UCR) Form
   g. Current Signed Service Agreement
   h. Signed Service Agreement Amendment (if applicable)
   i. Functional Screen Tool (FST) (the current open certification number must be documented on this form)
   j. Health Risk Screening Tool (HRST) Results
   k. Supports Intensity Scale (SIS) Results
   l. Respite Service Agreement (required only for Respite)
   m. Other Medical / Psychological Evaluations (as available)

3. For Specialty Services (including but not limited to risk assessments, counseling, START services, gentle teaching, nurse specialists and parent aide) the Service Coordinator will forward the PA Approval Packet to One Sky’s Director of Integrated Services. After the Director of Integrated has reviewed and approved the PA Approval Packet he/she will return it to the Service Coordinator.
4. The Service Coordinator will submit the PA Approval Packet to Service Coordinator Team Manager for review and approval.

5. The Service Coordinator Team Manager will forward the PA Approval Packet to the Director of Service Coordination for review and final approval.

6. The Service Coordinator will submit the completed and approved PA Approval Packet to the Financial Systems Administrator.

7. The Financial Systems Administrator will review the PA Approval Packet for completeness, review the recommended budget, confirm the new level of service being requested and forward the PA Approval Packet to the Billing and Accounts Receivable Specialist for his/her review and approval.

8. The Billing and Accounts Receivable Specialist will review the PA Approval Packet for completeness. If there is a current Unit Change Request (UCR) pending for any given client, the packet will be returned to the Service Coordinator and no further action will be taken until the outstanding UCR has been processed or a meeting between the Director of Service Coordination and Chief Financial Officer has been scheduled to discuss the new change.

9. For Annual Renewals and Changes the Billing and Accounts Receivable Specialist will print off and include in the PA Approval Packet a copy of the Current Approved Prior Authorization as well as prepare and include in the PA Approval Packet the appropriate Unit Change Request form.

10. The Billing and Accounts Receivable Specialist will then return the PA Approval Packet to the Financial Systems Administrator.

11. The Financial Systems Administrator will schedule a weekly PA Packet Approval Meeting with the Chief Financial Officer and CEO to review all PA Approval Packets received by him/her. The purpose of the meeting will be to obtain the Controller’s and – if necessary, the CEO’s - approval of each PA Approval Packet.

12. All annual commitments of over $25,000 will require signatures from two of the following individuals:

   a. Financial Systems Administrator
   b. Chief Financial Officer
   c. Chief Executive Officer

13. All annual commitments of over $50,000 will also require two signatures from the above list one of whom must be the Chief Executive Officer

14. Once a PA Approval Packet has been approved, the Financial Systems Administrator will
request and obtain BDS approval of the Proposed New Budget and enter that amount into the Budget Tracking System (BTS), or verify the funding in the BTS for renewals.

15. Once funding in BTS for the requested CCW services has been confirmed and after BTS is updated, the Financial Systems Administrator will forward the PA Approval Packet to the Billing and Accounts Receivable Specialist.

16. The Billing and Accounts Receivable Specialist will request a Prior Authorization (PA) by entering the data into the Prior Authorization Waiver System (PAWS) and submitting the PA Packet to BDS for changes and Conduent for new requests and/or renewals.

17. The Billing and Account Receivable Specialist will enter the PA Request into the Client Financial Tracking (“CFT”) system where a PA Request Number will be generated and the date that the PA Packet was submitted will be entered. The PA Packet will be scanned and saved on One Sky’s Business Office Financial drive and the original will be mailed to BDS.

18. Within the following time frames after a PA Request has been submitted:
   - Initial Prior Authorization: 90 Days
   - Renewal Prior Authorization: 45 Days
   - Changes to Existing PA: 30 Days

   CMS (through the MMIS) will either

   a. Send a completed Prior Authorization (PA) form to the Billing and Accounts Receivable Specialist stating what type of services have been approved, how many units have been approved, what the total dollar amount has been approved and for how long a particular individual is eligible for each specific service; or

   b. Notify the Billing and Account Receivable Specialist that the PA Request has been voided. The notification that the PA Request has been voided will contain the reason for the void. The Billing and Account Receivable Specialist will then review the original PA Packet submitted, correct any issues and resubmit the entire packet to MMIS.

19. The Billing and Accounts Receivable Specialist will update PAWS, CFT and the Case Management System to indicate the date that approval was received and notify the Financial Systems Administrator that approval has been received.

20. The Financial Systems Administrator will prepare a written notification to the selected service provider (“Vendor”) that service may begin (the “Service Authorization Notification”) and e-mail it to the selected service provider, with copies to the Service Coordinator and the Client’s Guardian. **No new, renewed or changed services may be provided – or will be paid for – without a service provider having first received a Service Authorization Notification.** Once he /she has done so the Financial Systems Administrator will provide a Service Authorization Notification to the selected service provider.
21. The Financial Systems Administrator will run a monthly PA Expiration Report out of NH Leads and email it to all Service Coordinators, the Service Coordinator Team Managers and to the Director of Service Coordination 90 days prior to expiration of current PA.

22. If there are no changes in the requested services or budget for those services, the assigned Service Coordinator will re-apply for the Waiver each year by submitting to the Billing and Accounts Receivable Specialist no later than 60 days prior to expiration, the following documents (PA Renewal Packet):
   a. Medicaid ID#
   b. Confirmation of Medicaid Eligibility
   c. Current Signed Service Agreement (required for only the first 3 years of services)
   d. Functional Screen Tool (FST) (the current open certification number must be documented on this form)

21. The Billing and Accounts Receivable Specialist will print off and include in the PA Approval Packet a copy of the current approved prior authorization. He/she will then enter the completed information into PAWS on or after the fifteenth of the month and submit the packet to Conduent.

22. BDS logs into the MMIS system to review the PA Renewal Packet and approves/denies the renewal.

23. If approved, Conduent mails the approval to the Billing and Accounts Receivable Specialist who then enters the approved PA into PAWS and notifies the Financial Systems Administrator.

24. The Financial Systems Administrator then prepares and sends out the Service Authorization Notification.

25. As part of the annual renewal process, every attempt should be made to discuss and include any changes in the requested level of services at that time. Any changes in the type or level of services or the budget for those services must be processed and reviewed following the procedure stated above starting with paragraph 1.

26. Off PA Cycle changes may only be made by exception only and requires the approval of the Chief Executive Officer. Changes of this type should be limited to exceptional circumstances where a client is in a demonstrated crisis situation. In these cases the Service Coordinator will prepare a written justification of why a change is needed at this time accompanied by the following:
   a. Medicaid ID#
   b. Confirmation of Medicaid Eligibility
   c. Current Approved Prior Authorization, which should be obtained from the Billing
and Accounts Receivable Specialist

d. Proposed New Budget
e. Description of the Service Offered (the “Blurb”)
f. A Completed Unit Change Request (UCR) form, which should be obtained from the Billing and Accounts Receivable Specialist
g. Current Signed Service Agreement
h. Signed Service Agreement Amendment (if applicable)
i. Functional Screen Test (FST)

27. All Off PA Cycle Changes should be presented by the Director of Service Coordination to the Chief Financial Officer and the Chief Executive with a justification of why such a change is required at that time. If the Off PA Cycle Changed is approved by the Chief Executive Officer, then steps 3 through 18 above should be followed.

28. In the event that a service is being terminated, the Service Coordinator will inform the Financial Systems Administrator, who will update BTS and inform the Billing and Accounts Receivable Specialist not to reapply for that specific service.

29. The Billing and Accounts Receivable Specialist will review the Community Care Waiver/Medicaid Pending Claims Report for discrepancies in services rendered and existing Prior Authorizations. Appropriate action shall be taken to correct the discrepancies.

30. The Billing and Accounts Receivable Specialist will communicate monthly regarding Prior Authorizations that have not been approved and forward to the Director of Service Coordination as applicable.
UCR Processing

Focus Area: One Sky Community Services, Finance and Accounting Department

The purpose of this procedure is to define when a Unit Change Request (UCR) is required, how to process and submit it so as to minimize the number and dollar volume of denied claims and improve organizational cash flow.

Policy

1. UCR’s are submitted on changes that need to be made to an existing Prior Authorization.
2. A change in service starts with a Service Coordinator, this can be adding services, adding units to a particular service level, reducing units to a particular service level, terminating services or adding an environmental modification.
3. Service Coordination follows the processes and procedures as documented in the PA Approval Process. Approved by the Board of Directors to obtain proper documentation and management approvals for the change request.
4. The Financial Systems Administrator gets the UCR and processes it in BTS.
5. The Financial Systems Administrator sends an email to the finance department and East Coast Billing notifying them of <WHAT>.
6. Once funding has been approved in BTS, the Financial Systems Administrator gives the approved PA Packet to the Revenue Accountant to prepare and submit the UCR packet to BDS’s PA Unit. This is usually done 10-14 days after the Financial Systems Administrator enters the budget change in BTS. <WHY DOES THIS TAKE SO LONG>?
7. The UCR Packet includes the following:
   a. PAWS Tracking Form <WHO PREPARES THIS>
   b. Email from the Financial Systems Administrator
   c. One Sky’s internal Budget and Prior Authorization Checklist
      i. Required signatures to include:
         1. Director
         2. Financial Systems Administrator
         3. CFO
         4. CEO
      ii. To Be Completed by Finance Box:
         1. Submission to BTS
         2. Approved in BTS
         3. Both signed off and dated by Financial Systems Administrator
   d. Service Coordination Blurb for UCR
   e. Amendment to Service Agreement
   f. Service Agreement
   g. Functional Screen
   h. Quotes (only for EMOD Requests)
8. A Unit Change Request Form or Environmental Modification Request Form are then completed based off the provided PAWS tracking sheet.
a. These documents can be found in the Department Drive; Business Office Folder; Prior Authorizations; PA Submission Forms
b. The PAWS tracking form will include:
   i. Name of Client
   ii. PA Number the change is affecting
   iii. PA Start and PA End Date
   iv. CCW Service Requested
      1. PA Change - This information is what should be updated in PAWS <JUST THE PA CHANGE, or ALL OF THE ABOVE?>
   v. The Unit Change Request form, will also include any date changes; e.g. if services get terminated prior to the PA end date, or a different service level starts after the PA start date.

9. Once the Unit Change Request form is complete, we will print one copy.

10. Once the packet is complete the Revenue Accountant will scan the following in this order:
    a. Unit Change Request Form
    b. Service Coordination “Blurb”
    c. Service Agreement Amendment
    d. Service Agreement
    e. Functional Screen

11. The scanned documents will get uploaded to E-Studio for the State’s PA Unit to review

12. Once the documents are uploaded the Revenue Accountant will receive an email, and change the title of the email for tracking purposes.

13. The Revenue Accountant will also track the progress of the completed and submitted UCR, this is done using an internal document which is found in:
    a. Department Drive; Business Office Folder; Prior Authorizations; PA Tracking; “UCR Tracking Sheet”
       i. The first tab “UCR Date Checked” will include:
          1. Name, PA Packet Number, Date submitted, and Date Checked
          2. Color Coded names will be used
             a. Green means the UCR has been approved
             b. Yellow means the UCR is 30 days Past submission
       ii. The Second tab “UCR Approvals” will be for approved UCR’s and will include:
          1. Name, PA Number, Update PAWS Y/N, Email East Coast-Y/N
       iii. The third tab “Past Due” will be for follow ups that are past 30 days from submission and will include:
          1. Name, PA number, Emailed State-Y/N, Date of most recent Follow up

14. The Revenue Accountant will hold onto the physical folders and follow up with MMIS twice weekly, Tues/Thurs or Weds/Fri. The Folder will include:
    a. The Submitted UCR form Date stamped, to confirm date of submission
    b. Email from the Financial Systems Administrator
    c. PAWS Tracking Form
    d. Budget and Prior Authorization Check List
15. Once the Revenue Accountant confirms that the UCR has been approved in MMIS, he will:
   a. Verify the correct approved units and dollar amounts
   b. Update the Approval Tab <WHERE?>
   c. Enter the UCR Into PAWS <Specify what and where>
   d. Notify East Coast Billing and Financial Systems Administrator that the UCR has been approved and entered into PAWS

16. Upon receipt of notification that the UCR has been approved in MMIS, the Financial Systems Administrator will notify the selected service provider (vendor or family representative) and Service Coordinator that services documented in the UCR are authorized to begin.
   a. Pursuant to the PA Approval Process approved by the Board of Directors any exception to this step of the procedure must be approved by the CEO.
   b. In the event that services have been authorized to begin before the UCR has been approved in MMIS and entered into PAWS and East Coast Billing receives an attendance sheet for the services reflected in the UCR, East Coast Billing will bill for such services. East Coast Billing will not hold up any billing for services while waiting for notification that a UCR has been approved and entered into PAWS. It is expected that when this occurs it will result in an increase in pending claims.

17. The Revenue Accountant will monitor pending and/or denied claims and follow up as needed internally, with the service provider and/or the PA Unit within BDS to resolve any issues in billing for Medicaid reimbursement associated with any unapproved UCR as quickly as possible.
Signature Designees

Focus Area: One Sky Community Services, Finance and Accounting Department

Whereas Section V.A.1 One Sky Bylaws originally adopted on December 6, 1982 and last updated on December 6, 2016 (the “Bylaws”) provides that the duly elected Board of Directors of One Sky (the "Board") shall administer all the funds of the Corporation and Section V.C.4 of the Bylaws provides that the Treasurer shall perform all duties described in the Bylaws unless the Board designates another person such as the Chief Financial Officer to perform such duties as the designee. On September 9, 2019 the Board adopted designated the following individuals with financial commitment and check signing authority to enable Management to operate efficiently and with appropriate safeguards.

For Non-Medicaid Funded Expenditures:

1. The following Department Directors are authorized to sign purchase orders committing One Sky to an expenditure of non-Medicaid budgeted funds of up to $1,000:
   a. Director of Service Coordination (currently Keryn Bernard-Kriegl)
   b. Director of HR and Administration (currently Tina Holmes)
2. All purchase orders for non-Medicaid budgeted and non-budgeted funded items over $1,000 must be co-signed by the Chief Financial Officer (currently John Moran)
3. All purchase orders for non-Medicaid funded items over $10,000 must also be approved by the Chief Executive officer (currently Chris Muns)
4. All purchase orders for non-Medicaid funded items not included in the approved current fiscal year budget over $20,000 must also be approved by the Finance Committee of the Board of Directors.

For Medicaid Funded Expenditures:

1. The following individuals are authorized to commit One Sky to the expenditure of Medicaid funds:
   a. Budgets and Contracts Specialist (currently Bill Northey)
   b. Chief Financial Officer (currently John Moran)
   c. Chief Executive Officer (currently Chris Muns)
2. All annual commitments of over $25,000 require two signatures.
3. All annual commitments of over $50,000 require two signatures, one of whom must be the Chief Executive Officer (currently Chris Muns)

Check Signing Authority

1. The following three individuals are authorized to sign checks issued by One Sky:
   a. Chris Muns – Chief Executive Officer
   b. John Moran – Chief Financial Officer
   c. Tina Holmes – Director of HR and Administration
2. Any one of the three aforementioned individuals may sign checks up to a maximum value of $5,000.
3. Checks in excess of $5,000 require two signatures
4. Checks in excess of $50,000 require two signatures, one of which must be the Chief Executive Officer (Chris Muns)
Readiness Fund

Focus Area: One Sky Community Services, Finance and Accounting Department

The ONE SKY READINESS FUND ("Readiness Fund") was created to directly address critical essential client needs that are not funded through available Medicaid or State of New Hampshire general funds. All funds raised in the name of the ONE SKY READINESS FUND will be used exclusively for the scope of services defined in this policy.

One Sky Community Services ("One Sky") will do all that it can to assist those clients who have exhausted all other available resources and are in need of funding to address an extraordinary need that may arise. We are also committed to doing what we can to address other more systematic issues where existing state and federal funding has proven inadequate to the need that exists.

SCOPE:

The following are the key areas we have identified as essential to meeting the needs of those we serve:

- **Dental Services Program**
  
  Unfortunately, most of the adults we serve are not covered for dental care in the state of New Hampshire. It has been proven that a lack of decent and appropriate dental care can lead to serious health issues, but it can also create significant self-esteem issues, making their social and economic challenges that much more difficult. Most of our adult clients are at the stage of requiring extensive dental work and care.

- **Emergency Assistance Program**
  
  There are many times when those we support need vital assistance with some aspect of their everyday life, which traditional programs of support will not cover. This can range from basic clothing, food, fuel assistance, temporary housing, and medical supplies.

  The Readiness Fund will enable us to give monetary support to those individuals living marginally, who simply require our assistance with basic living needs and safety devices until they are in a better position, socially and economically, to support themselves.

- **Gas, Food, and Home Heating Voucher/Card Program**
  
  Often when a child is born with a disability, family members miss a substantial amount of work, sometimes losing pay, because they are required to travel for specialized care on a regular basis. This program can have a significant impact on the family’s financial situation. Food, gas, and home heating vouchers/cards can greatly ease travel costs and income loss.
• Home Modifications and Repairs

The affordability of home modifications and repairs are increasingly becoming an issue for our clients. Architectural barriers to bathrooms and kitchens, installation and repairs of ramps, widening doorways, and environmental controls and so on, can be expensive endeavors. We need to ensure that these needs are met to continue improving their daily activity and their ability to remain at home as independently as possible.

• Summer Camp Scholarship Program

Everybody deserves a period of rest and reflection and we have found that one of the many ways we can assist our clients, particularly children, is providing the opportunity to attend an educational summer camp. This is a very popular program at One Sky and has been greatly reduced due to funding shortages. Many NH camp programs offer activities that are educational and fun, where one can learn new skills and be exposed to new cultural and historical adventures that will broaden their horizons.

• Recreational and Cultural Activities and Opportunities

One aspect of living a well-rounded and fulfilling life is to have the opportunity to be exposed to new cultural and educational experiences. We want to be a position where we can offer those opportunities to the people we serve through the One Sky purchase of group tickets to various educational, cultural, and historical activities and events throughout New Hampshire during the year.

• Client-Centered Employment Training Program

We believe there is a job for everyone we support. The challenge is finding (or creating) that job which matches the interests, skills, and needs for each of those individuals. To do this, we need to build a network infrastructure within the business community to enlist not only their support, but to bring clarity and understanding of the many advantages hiring people with Developmental Disabilities and Acquired Brain Disorders offer their business. But it also means having the resources available to invest in this new business opportunity.

Client-Community Transportation Program

Many of the individuals we support are either unable to drive a car, or do not have access to reliable and safe public transportation. When they get a job, they must arrange for transportation to and from work. There is no state or Medicaid funding to provide such support. We need to create a program that will tie into already existing transportation efforts to provide a regional system to accommodate and provide direct support to those who are in most need, with the possibility of purchasing van(s) for One Sky to use for those who cannot be accommodated through this program due to unique circumstances.
(to be driven by One Sky volunteers). Because one single organization cannot “do it all” success will be achieved through the creation of partnerships with complementary groups and entities.

ROLES AND RESPONSIBILITIES:

A. Any employee of One Sky may submit a request for funding from the Readiness Fund but it is expected that most requests will be submitted by Service Coordinators on behalf of their clients.

B. A Readiness Fund Vetting Committee (the “Committee”) has been created. Members of the committee include:
   1. Director of Outreach and Development (who shall serve as the chairperson of the Committee);
   2. Director of Human Resources and Administrative Services;
   3. Senior Staff Accountant

C. The Committee will meet the second and fourth Thursday of each month to review submitted requests.

D. The Committee will maintain a record of its meetings, including a summary of requests received, reviewed and/or approved/denied.

PROCEDURE:

I. Receipts
   A. All receipts will be recorded and maintained in account # 2581-000-000, which resides on the balance sheet.
   B. Cash or check donations received in person will immediately be given to the Accounts Receivable Administrator for processing.
   C. Cash or check donations received by mail will be processed by the Front Desk Coordinator and forwarded to the Accounts Receivable Administrator.
   D. Online donations will be monitored and reconciled with payments received from online contribution platforms (such as PayPal) that One Sky may choose to utilize.

II. Disbursements
   A. Any employee wishing to submit a request for funding shall do so by submitting a Funding Request Form along with a written description that includes (at a minimum), the name of grantee, the amount of the funding request, the intended use of the requested funding and the reason for the funding request. All requests must indicate that all other available sources of funding have been exhausted.
   B. All requests should be submitted to the Director of Outreach and Development.
   C. Requests received by the second Monday of the month will be reviewed by the Committee at its meeting on the second Thursday of the month. Requests submitted by the fourth Monday of the month will be reviewed at the Committee’s meeting on the fourth Thursday of the month.
   D. Requests that require additional information or action, deemed necessary by the...
Committee, will be given back to the Director of Outreach and Development, who will then follow-up with the individual who submitted the original request for additional information.

E. Once that follow-up has been completed, the request will be reconsidered at the next Committee meeting for review and approval.

F. All requests approved by the Committee will be submitted to the Chief Financial Officer for his/her review and approval.

G. All requests over $1,000 and up to $20,000 will be submitted to the Chief Executive Officer for his/her additional approval. Should the Chief Executive Officer not be available to sign, requests will be submitted to the Director of Human Resources and Administration.

H. All requests over $20,000 will be submitted to the Board of Directors’ Finance Committee for their final approval.

I. All approved payments will be processed by the Accounts Payable Administrator. Payments will be made by check or, in certain circumstances, direct wire transfer. No cash payments are permitted.

J. The Senior Staff Accountant will produce a quarterly summary of donations received, payments processed, and outstanding Readiness Fund balance. This report will be submitted to the Committee, the CFO, CEO and the Board of Directors’ Finance Committee.
Client Representative-Pavee Funds

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

To assure that client funds are used only for allowable purposes for that specific client. Rep payee funds belong to a particular client and are available only for that client’s benefit. The individual funds are protected against theft or misuse.

a. Client rep payee funds are deposited in a special bank account maintained specifically for that purpose.
b. Receipts to the funds are handled under the cash receipts policy.
c. Occasionally a case manager may request funds from a client’s account without a receipt when necessary to effectively serve the needs of the client. Upon receipt of a completed check request the business office will issue a check.
d. The business office maintains a tickler file, by case manager, of disbursements without the appropriate documentation. If documentation is not received, the business office notifies the case manager that no further funds will be disbursed until appropriate documentation is received.
e. The case manager is responsible for the implementation of this policy.
f. The Financial Support Specialist maintains a ledger showing the receipts and disbursements for each client, and the balance due to/from each individual client.
g. The bank reconciliation for this account will be performed by someone other than the person responsible for writing the checks and depositing to this account.
**Debt**

**Focus Area:** One Sky Community Services, Finance and Accounting Department

To provide a framework for careful analysis before the Agency commits to the acquisition of debt.

All borrowing must be authorized by the Board of Directors

1. The Chief Financial Officer, after consultation with the Chief Executive Officer and the Finance Committee, provides detailed analysis of any prospective borrowings to the Board of Directors.

2. The Board of Directors must approve all loans prior to inception.

3. If Management projects that there will be a short-term cash deficiency necessitating the need to access short-term debt through a line of credit secured through one of the Corporation’s banks, the Board approves the following procedures:
   a. For requests to access up to $100,000 in short-term debt:
      i. The Chief Executive Officer or in his/her absence the Chief Financial Officer shall make a written request to the Corporation’s Treasurer or in his/her absence the President of the Board of Directors for the amount to be requested. Such written request will include a current projection of cash needed for the following 12 weeks as well as an indication when the short-term debt will be paid off.
      ii. The Board authorizes the Treasurer or in his/her absence the President of the Board of Directors to approve any such request up to $100,000.
   b. For requests to access between $100,001 and $250,000 in short-term debt:
      i. The Chief Executive Officer or in his/her absence the Chief Financial Officer shall make a written request to the Corporation’s Treasurer or in his/her absence the President of the Board of Directors for the amount to be requested. Such written request will include a current projection of cash needed for the following 12 weeks as well as an indication when the short-term debt will be paid off.
      ii. The Treasurer or in his/her absence the President of the Board of Directors shall call an emergency meeting of the Finance Committee to consider the request. Such meeting may take place in person or by conference call.
      iii. The Board authorizes the Finance Committee – through a majority vote of its members - to approve any such request up to $250,000.
      iv. In the event any vote of the Finance Committee is a tie, then the Treasurer will immediately contact the President of the Board of Directors and request an emergency meeting of the full Board so that the request can be considered. Such meeting may take place in person or by conference call.
   c. For all requests to access short-term debt of greater than $250,001:
      i. The Chief Executive Officer or in his/her absence the Chief Financial Officer shall make a written request to the Corporation’s Treasurer or in
his/her absence the President of the Board of Directors for the amount to be requested. Such written request will include a current projection of cash needed for the following 12 weeks as well as an indication when the short-term debt will be paid off.

ii. If the Treasurer or in his/her absence the President of the Board of Directors determines that the request is warranted, he/she will immediately contact the President of the Board of Directors and request an emergency meeting of the full Board so that the request can be considered. Such meeting may take place in person or by conference call.

4. Only the full Board of Directors is authorized to approve any request to access short-term debt in excess of $250,001.

The Chief Financial Officer is responsible for the safekeeping of all loan documents, and for monitoring compliance with debt agreement restrictions and procedures.
Credit Cards

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

Credit cards are for business use only. No personal purchases are to be made using a One credit card.

The President/CEO’s expense records are submitted to the Board on a quarterly basis. The CFO may question any expense that appears not be Finance and Accounting-related.

On September 9, 2019, the Board authorized the following individuals to be issued One Sky credit cards:
   a. CEO (Currently Chris Muns)
   b. Director of HR and Administration

These individuals keep their cards and are responsible for obtaining proper approval signatures on charges and submitting receipts to the Finance and Accounting Department. All credit card purchases over $100 must be pre-approved by the Chief Financial Officer.
Mail Distribution

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

1. All incoming mail is handled by the Receptionist. All mail will be date-stamped and distributed to the proper mailboxes, with the following exceptions.
   a. Do not open Bank Statements. Forward all Bank Statements to the CFO.
   b. Do not date stamp checks. Follow Daily Deposit Procedure.
   c. Do not open mail specifically addressed to the HR Coordinator.
   d. Do not open items addressed to individuals that are marked confidential

2. All incoming mail is handled by the Receptionist. All mail will be distributed to the proper mailboxes, with the following exceptions.
   a. Bank Statements will be forwarded to One Sky CFO
   b. Incoming checks will be entered on an incoming check log and sent to One Sky Senior Accountant
**Purchasing**

**Focus Area:** One Sky Community Services, Finance and Accounting Department

**Policy**

The purchase of goods and services should be done in a cost-effective and efficient manner to aid the work of the staff. Purchasing limits and the associated practices are set by the Board and the CEO.

**Purchasing Dollar Limits**

The One Sky CEO has been authorized by the Board to make purchasing decisions for amounts less than $20,000 without obtaining Board approval. Purchases of non-budgeted items of more than $20,000 will be presented by the CEO to the Finance Committee at their next scheduled meeting.

**Sole Source Justification**

A sole source purchase is one in which an item or service is available from only one vendor or one in which there are multiple sources available but the item or service must be purchased from a specific vendor for a specific reason. Such reasons could include but are not limited to:

- emergencies
- time sensitivity
- competitive product alternatives are not available
- compatibility of equipment must match existing brand and/or
- replacement part for a specific brand of existing equipment

When a sole source will be used to purchase a product or service with a cost over $20,000 a written justification is required and should include the following information:

- A description of the product or service the reasons that this vendor is being used.
- A description of efforts made to locate other sources of supply.
- Documentation that the anticipated cost is fair and reasonable. This can be a comparison of prices or if the item is to be specially fabricated, an analysis of the manufacturer’s cost.
- Any other supporting information.

This justification for sole source should be included with the request to the Board to approve the purchase over $20,000.

When a sole source will be used to purchase a product or service with a cost over $20,000 the CEO may make that decision.
Sole sourcing for more than 3 years is subject to review and should be competitively bid before another contract/purchase is finalized

**Construction/Capital Improvement/Contract Purchases Over $20K**
- All construction/capital improvement purchases. Three (3) competitive bids are required.
- Major capital or operational item purchases (computers, copiers). Three (3) competitive bids are required.
- Contracts for services. No contract may exceed 3 years. Three (3) competitive bids are required.

Approval Process:

1. Finance Committee must review and approve
2. Full board must review and approve.

**Requirements for Receiving Proposals For Services, Property Or Major Purchases less than $20K**

1. **Proposals For Services**

   Proposals for services and programs are designed to assist the family and their family member to choose the support, control and flexibility to fit their individual needs. The decision for service is at the discretion of the director of service and the family.

2. **Proposals For Property Or Major Purchases**

   Proposals for capital purchases are at the discretion of the director of the program and reviewed at Senior Leadership Team meeting for final approval.

   Written quotes are accepted for capital, major purchases, and contracts as deemed necessary by the CFO and/or CEO.

**Purchase Requests (One Sky) and Purchase Orders (PLUS Company)**

Any employee of One Sky who wishes to purchase any product or service that is not a Medicaid Community Care Waivered (CCW) service will fill out and submit for approval a purchase order request prior to any agreement to purchase that product or those services is entered into.

Examples include:

a. Monthly or quarterly purchase order for office supplies from a given provider;
b. Annual service agreement with a computer services company
c. Annual maintenance agreement with computer or office equipment provider
d. One time purchase of a new appliance for a staffed home that we may own.

This procedure recognizes that it is not always possible to obtain a written quote or estimate of the cost to provide professional services (such as legal or clinical assistance). In those instances it is important that the service provider provide timely invoices for service delivered so that we are aware and are able to manage our total potential liability for the costs of those services in a timely manner.

An employee filling out the Purchase Order Request Form must include

a. The date of the request
b. A description of the item or service to be purchased
c. The quantity or length of the term of the services to be provided
d. The unit and total price and preferred vendor or service provider, if known

He or she should sign the request and forward it to her/his Department Director.

Department Directors are responsible for filling in the following information on the Purchase Order Request Form:

a. GL Account #
b. Cost Center
c. Unit and total price of the item or service to be purchased (if not provided by the Purchase Order Requestor)
d. Preferred Vendor or Service Provider (if not provided by the Purchase Order Requestor)
e. The Requested Delivery Date

Department Directors should sign all Purchase Order Requests submitted by members of their department. Department Directors have final approval authority on all budgeted purchases up to $1,000. Approved Purchase Order Requests for budgeted items of less than $1,000 should be forward by the Department Director to the Accounts Payable Specialist for processing. The only exception to this policy is purchases of office supplies and computer equipment. All requests for office supplies and computer equipment should be approved by a Department Manager and then forwarded to the Director of HR and Administration her/his review and approval.

Approved Purchase Order Requests for budgeted items over $1,000 and all Purchase Order Requests for non-budgeted items should be submitted to the CFO for his/her final review and approval. The CFO will then forward the Purchase Order Request to the Accounts Payable Specialist for processing.

Approved Purchase Order Requests of more than $10,000 should be forwarded by the CFO to the CEO for her/his approval. Once the CEO has approved a Purchase Order Request she/her
will forward it to the Accounts Payable Specialist for processing.

Purchases Order Requests for non-budgeted items of more than $20,000 will be presented by the CEO to the Finance Committee at their next scheduled meeting. In the event the funding request is to address an emergency the Finance Committee will be able to act on the request via telephone conference call or email.

Upon receipt of an Approved Purchase Order Request, the Account Payable Specialist will:

a. Review the Purchase Order Request to ensure that all of the required data elements have been filled in.
b. Fill in the Customer ID field
c. Assign a number to the Purchase Order Request Form
d. Place the order with the preferred vendor or service provider by faxing, emailing or mailing them a copy of the approved Purchase Order Request Form; ensuring that the vendor or service provider understands that
   i. All invoices for the items or services ordered should be sent directly to the Accounts Payable Specialist.
   ii. All invoices should reference the assigned Purchase Order Number
   iii. The only exception to this policy is that orders for office supplies and computer equipment will be placed directly by the Director of Administrative Support Services. All approved Purchase Order Request Forms for office supplies and computer equipment should be forwarded by the Accounts Payable Specialist to the Director of Administrative Services after the Account Payable Specialist has reviewed it.
e. File the original approved Purchase Order Request Form in an easily retrievable folder.

Upon the receipt of an invoice for items or services purchased, the Accounts Payable Specialist will match the invoice with the corresponding Purchase Order Request Form. If the amount on the invoice is less than or equal to the approved amount on the Purchase Order Request Form the Accounts Payable Specialist will attach a copy of the approved Purchase Order Request form to the invoice and process the invoice for payment net 30 days.

Any invoice for services in excess of the amount on the approved Purchase Order Request Form will be forwarded to the Department Director who approved the Purchase Order. That Department Director will be responsible for working with the vendor or service provider to resolve the difference. All amendments to an approved Purchase Order Request Form must be reviewed by first the CFO and then the CEO. Once all issues have been resolved the Accounts Payable Specialist will attach a copy of the approved Purchase Order Request form to the invoice and process the invoice for payment net 30 days.

All vendors or service providers will be encouraged to accept payment by ACH. It is the responsibility of the Account Payable Specialist to notify all vendors and service provider of this service and to sign them up for it.
All checks or ACH Request for payment of approved products or services delivered must be signed by one for the following three individuals:

a. CFO
b. Director of HR and Administration
c. CEO

Checks or ACH Requests for payment of approved products or services delivered in excess of $5,000 must be signed by any two of the following:

a. CFO
b. Director of HR and Administration
c. CEO
Accounts Payable

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

One Sky Community Services, Inc. is responsible for the proper use of significant amounts of public funds. The agency must assure that these funds are used in accordance with its mission of providing appropriate care to its clients, and in compliance with all contractual requirements.

Prior to disbursement of any funds, the agency determines:

a. That the appropriate goods or services were received in the quantity specified and in good condition, and
b. Terms and pricing are acceptable, and
c. The party requesting payment has submitted an invoice for the amount requested., and
d. The disbursement is in accordance with the state contract and all other applicable laws and regulations, and
e. Funds are available in the budget line for this item.

One Sky follows the expense recognition principle of accounting which states that expenses should be recognized in the same period as the revenues to which they relate.

Invoices received for services delivered but not yet paid will be reported as “Accounts Payable”. Accruals for services delivered but for which invoices have not yet been received will be reported as “Accrued Expenses Not Yet Paid”

a. Prior to purchasing supplies, a purchase order will be prepared by the purchaser, signed by a supervisor and submitted for approval by the Chief Financial Officer. A copy of the approved purchase order is submitted to the Accounts Payable Department.
b. The staff member receiving the goods or services signs the invoice after checking the quantity and condition of the items received. The signature indicates original approval of the invoice for payment
c. The invoice then goes to the department head for his/her approval. The invoice is then routed to the Accounts Payable Department for processing.

Payments to Direct Service Providers (“Vendors”) will be based upon signed fee agreements as follows:

a. Residential Programs

i. Residential program payments to Vendors will be made following service delivery. Payments will be made on a per diem basis based on actual Daily Attendance Records submitted. The rate paid will be the annual residential budget divided by 365. The reimbursement for a Consumer will not exceed their annual budget (prorated for a mid-year start date) subject to the conditions below and provided the Vendor has
delivered to Consumer 327 days of services over the course of a twelve month period. Payments will be made three weeks after receipt of Daily Attendance Records.

ii. At the end of each calendar quarter (ending September 30, December 31, March 31 and June 30) One Sky will reconcile YTD payments made to each Vendor to actual days services were delivered to Consumer by that Vendor. If Vendor has delivered the following days of services through each quarter end, One Sky will make a Quarterly Adjustment Payment to Vendor as follows:

<table>
<thead>
<tr>
<th>Quarter Ending</th>
<th>If YTD Days of Services Delivered Equals or is Greater Than:</th>
<th>Quarter Adjustment Payment Will Equal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30</td>
<td>81 days</td>
<td>25% of Annual Budget Minus Actual YTD Payments</td>
</tr>
<tr>
<td>December 31</td>
<td>162 days</td>
<td>50% of Annual Budget Minus Actual YTD Payments</td>
</tr>
<tr>
<td>March 31</td>
<td>243 days</td>
<td>75% of Annual Budget Minus Actual YTD Payments</td>
</tr>
<tr>
<td>June 30</td>
<td>327 days</td>
<td>100% of Annual Budget Minus Actual YTD Payments</td>
</tr>
</tbody>
</table>

b. Community Participation Programs (CPS)

i. Day program payments to Vendors will be made following service delivery. Payments will be made based on actual Daily Attendance Records submitted in ¼ hour units. The rate paid will be the annual day budget divided by the ISA expected hours of service to be delivered multiplied by 4 (For example: the ¼ hour unit rate paid for 30 hours of services per week for a program with an annual budget of $20,000, would be $20,000 divided by 1,560 hours times 4 or $3.21 per unit). The reimbursement for a Consumer will not exceed their annual budget (prorated for a mid-year start date) subject to the conditions below and provided the Vendor has delivered to Consumer 89% of the ISA expected units of service over the course of a twelve month period. Payments will be made three weeks after the delivery of Daily Attendance Records.

ii. At the end of each calendar quarter (ending September 30, December 31, March 31 and June 30) One Sky will reconcile YTD payments made to Vendor to actual units of services delivered to Consumer by Vendor. If Vendor has actually delivered 89% or greater of the YTD ISA expected units of service, One Sky will make a Quarterly Adjustment Payments to Vendor as follows:

<table>
<thead>
<tr>
<th>Quarter Ending</th>
<th>If YTD Units of Services Delivered as a Percentage of YTD ISA Expected Units of Services</th>
<th>Quarter Adjustment Payment Will Equal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30</td>
<td>89%</td>
<td>25% of Annual Budget Minus Actual YTD Payments</td>
</tr>
<tr>
<td>December 31</td>
<td>89%</td>
<td>50% of Annual Budget Minus Actual YTD Payments</td>
</tr>
</tbody>
</table>
At the end of every month, One Sky records those services we have billed Medicaid for but which a Vendor has not yet invoiced us for on our balance sheet as Accrued Expenses Not Yet Paid since it is assumed that the Vendor will be providing us with an invoice for these services shortly. The balance in this account is adjusted monthly based on year-to-date activity and every quarter based on the quarterly reconciliation of payments to each Vendor that is completed.

Payments for Self-Directed Services (PDMS/HIS) will be based upon signed fee agreements as follows:

a. An equal portion of the annual stipend amount included in the approved PDMS or IHS budget will be paid to the designated PDMS or IHS program manager once (1/12 of the annual total) or twice (1/24 of the annual total). At the end of each calendar quarter (ending September 30, December 31, March 31 and June 30) One Sky will reconcile YTD payments made to designated PDMS or IHS program manager to actual units of services delivered to Consumer.

b. The PDMS or IHS program manager will submit all other invoices to the Accounts Payable department for processing.

Members of families receiving respite services will forward vouchers for payment to the Accounts Payable department, where they will be matched with list of individuals approved to receive respite services prior to processing.

The Chief Financial Officer reviews all invoices prior to check signing. He/she authorizes the release of the funds based on the availability of adequate cash in the accounts.

Properly approved invoices received before noon on Wednesday are processed and paid on Friday. Invoices without the required approvals are returned to the originating department, and may not be paid in the current week.

Manual checks require the same approvals as any other disbursement. They are entered on the general ledger system through the accounts payable system.

Voided checks are defaced (cut out the signature space or stamped VOID) and retained for audit trail purposes.

Payments to certain independent Vendors (described in the Circular E Payroll Guide) are totaled for the year and reported to the vendor on Form 1099 at the end of the year.

Someone other than the person processing checks will perform the bank reconciliation for this account.
Payroll Processing

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

Sensitive payroll information is kept in secure storage and released only to authorized personnel. All employees are paid for the correct number of hours worked at the authorized pay rate in accordance with agency policy and in compliance with all applicable laws and regulations.

a. Prior to bi-weekly payroll processing, any staff changes in position, rate, status, classification of employment are reviewed and signed/approved by supervising manager as well as the CEO and CFO. Changes are made via ADP (electronic payroll and timekeeping system).

b. All changes are reviewed and verified bi-weekly by Director of HR and Administration.

c. For family-hired (PDMS, self-directed programs) not on the electronic timekeeping system, blank hourly timesheets e-mailed or printed and given to staff at orientation. Family supervisors/staff are responsible for faxing/scanning/mailing/delivering completed paper timesheets on a bi-weekly basis.

d. Employees must log into and submit before managers can approve timesheet. ADP timecard submissions are due bi-weekly by Monday 9am for all employees, Managers are to approve electronic timesheet submissions by 10am on Tuesdays of pay weeks. Employees must log in to submit before managers can approve timesheet. Payroll Coordinator e-mails/contacts appropriate supervising manager if the timesheet deadlines are not met. If electronic or paper submissions and approvals do not occur before deadline of payroll processing, a manual check may be requested (issued through Accounts Payable). A signed paper timesheet will be required and will then be retained in the Payroll files.

e. A summary report with all family-hired hours is given to the HR department for review and a grand total is calculated. The Payroll Coordinator uses this for the manual entry input into ADP.

f. The Payroll Coordinator imports the electronic ADP entries and manually inputs the hours from paper timesheets. Payroll is submitted to the ADP by end of day on Tuesday of pay week.

g. The Payroll Coordinator runs a report of benefits (i.e 403(b), FSA) after each pay and submits payment electronically to appropriate vendors.

h. Any Third Party Sick Pay is entered through ADP to update year-to-date earnings; Social Security and Medicare withholdings.
i. Quarterly statements are retrieved from ADP and reconciled by the Payroll Coordinator.

j. The Payroll Coordinator is responsible for receiving and verifying invoices for all employee deductions such as: Health and Dental insurances, Group Term Life, Additional Life Insurance, Long and Short-Term Disability, AD&D Insurance. Once deduction rates are verified, invoice is forwarded to Accounts Payable for processing.

**Payroll Status Change Process**

*Current Employee*

a. Any supervising manager seeking to make a change (including but not limited to change in hours, pay rate, job code, allocations, bonus pay outs and/or termination of employment) to a current employee will Complete a Personnel Change Request (PCR).

b. Per the NH Department of Labor, if a change occurs to the employee's pay rate, or benefits then a letter must be signed by the employee acknowledging that change. The HR Director or designee will generate a letter or an updated job description and have the employee sign off on it.

c. The Personnel Change Request (PCR) will have all necessary & accurate information regarding this employee, in regard to what is being changed. Once generated, the PCR will be processed as described in Payroll – item #1.

d. Once changes are entered into ADP, the original Payroll Status Change Form is placed in the employees personnel file.

*New Employee*

a. When hiring new staff, the supervising manager will notify the HR department so that an orientation can be scheduled and appropriate forms can be signed.

b. HR will pass all completed paperwork to the Payroll Coordinator to enter information into ADP. After new employee is entered into ADP, all information is filed into the employee's personnel record.

**Pay Day:**

Distribution is as follows:

a. Payroll register is printed and given to CFO for review and signature on Wednesday morning. All payroll check registers and reports are saved on the HR and Business Office drive on network.
b. Paychecks arrive on Wednesday afternoon.

c. Confirmation of cash available is required of the Accounting Manager. Once received, the Accounting Supervisor transfers cash from operating to payroll account.

d. Paychecks are handed over to the Senior Accountant to place in company safe. Senior Accountant places paychecks for outside staff in the outgoing mail by Noon on Thursday. Paychecks for in-house staff are placed in staff mailboxes on Friday mornings by the Senior Accountant.
Employee Benefit Cost Accounting (Healthcare, 403B and FSA)

Focus Area: One Sky Community Services, Finance and Accounting Department
Travel Reimbursement

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

Allowable employee expenses incidental to the performance of duties are reimbursed upon completion of an employee expense report.

a. Agency use of an employee's personal automobile is reimbursable at the rate currently approved by the agency. The Agency use of a personal automobile must be authorized by the employee's supervisor.
b. Employees are required to present proof of insurance prior to utilizing a personal automobile for Agency purposes.
c. Transporting clients without acceptable insurance is cause for immediate dismissal.
d. Meal costs are reimbursable when the employee is away from home overnight on agency business or is attending a required Agency meeting where meals are not served.
e. Expenses incurred for entertainment or alcoholic beverages are not reimbursable.
f. Parking and moving violation fines are not reimbursable.
g. Request for reimbursement are submitted monthly.
h. The reimbursements request must include the name of the employee, date the expense was incurred, date of the request for reimbursement, a description of the purpose or nature of each expense item, miles traveled, dollar amount for mileage, tolls, meals, room, and other expenses, the requesting employee's signature, the supervisor's signature, and date and the Department Director's signature and date if different from the supervisor.
**Family Expense Authorization**

**Focus Area:** One Sky Community Services, Finance and Accounting Department

**Policy**

**Family Expense Authorization**

1. This form is used by the **One Sky Family Support Coordinators only**.

2. When a family is in need they contact a Family Support Coordinator for funds. The coordinator completes a Family Expense Authorization.
   
a. The form is then given to the Director of Family Support for signature approval.

b. The form is given to the Accounts Payable Specialist to enter into Solomon for payment the first Friday of the week following the request.
Petty Cash Funds

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

To safeguard the contents of the petty cash funds against improper use or theft, designated petty cash fund custodians are subject to special procedures set forth below to assure that the contents are available for the intended use.

a. A copy of this policy must be kept with each petty cash fund.
b. The Director Finance designates petty cash fund custodians and determines the amount of each fund. The A/P Specialist has responsibility for the Fund.
c. The funds are maintained on an "imprest basis" which means that the cash and vouchers in the fund always consist of a certain fixed amount.
d. Personal use of funds by employees is strictly prohibited. Loans to employees and the cashing of employee checks from the fund are also prohibited.
e. The fund is to be used only for necessary business transactions. Any disbursement from the fund must be authorized by a signature of the recipient on the disbursement log completed in ink accepting receipt of funds for the amount of receipt or voucher submitted.
f. Reimbursement to the petty cash fund is made in the form a check written to the A/P Specialist. The amount of the reimbursement is for the amount of the receipts/vouchers submitted for reimbursement.
g. Petty cash funds are subject to unannounced counts.
h. The fund custodian is responsible for compliance with this policy and for safeguarding the fund contents. The fund must be locked in a safe place except when disbursements are being made.
Consumer Benefits

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy
1. Spend-Down:
   a. A Spend-Down request form is completed when a consumer has exceeded their Medicaid limit.
   b. The Service Coordinator is responsible for completing the form.
   c. Checks will be issued to the vendor. A copy of the request will be attached to the check.
   d. All receipts/cash are due as indicated on the copy of the Spend-Down Request to the Accounts Payable Specialist.
   e. A copy of the original Spend-Down Request will be kept in a tickler file.
   f. Once all the receipts are returned, the originals are kept in the Accounts Payable files.

2. Consumer Funds
   a. A Request for Consumer Funds form will be completed and approved by the Service Coordinator and submitted to the Client Benefit Services Manager for approval. This Form is then submitted to AP for processing.
   b. Reimbursement checks are issued when receipts are attached to the form.
   c. Receipts are required for spending other than normal weekly/monthly spending, on amounts over $50.00.
   d. All receipts are due to AP by the date indicated on the Request.
   e. A copy of the Request is kept in a tickler file until all receipts are returned.
   f. Once the receipts are returned, the original request with receipts, are filed in the Accounts Payable files.
Billing and Accounts Receivable

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

One Sky Community Services, Inc. is responsible for the proper use of significant amounts of public funds. The agency must assure that these funds are used in accordance with its mission of providing appropriate care to its clients, and in compliance with all contractual requirements.

One Sky will promptly bill and request payment for services delivered from:
   a. State of New Hampshire; for both Medicaid and non-Medicaid funds, and
   b. Consumers who have agreed to pay for services directly, and
   c. Other parties for whom One Sky has provided services

One Sky follows the revenue recognition principle of accounting which states that revenue should be recorded when it has been earned, not when the related cash is collected.

One Sky also follows the accounting principles that revenues and expenses related to the performance of a specific service should be recognized in the same time period.

Billings for services delivered but for which payment has not yet been received will be reported as “Accounts Receivable”.

Accruals for services delivered but which have not yet been billed for will be reported as “Accrued Revenues Recognized Not Billed Yet”

Billing for all services payable by Medicaid are handled by East Coast Reimbursement Services (ECRS) under a contract they have with One Sky. ECRS follows the procedures documented in the attached “One Sky Billing Instructions” – See Exhibit A

Attendance sheets are forwarded to East Coast Reimbursement Services directly from those Direct Service Providers (Vendors) under contract with One Sky to provide services to Consumers of One Sky.

East Coast Reimbursement Services bills Medicaid

Claims that are denied are reported on our balance sheet as AR Medicaid Denied until such time as outstanding issues are resolved and then are reported as Accounts Receivable-Medicaid until payment is received.

Claims that are pended are reported on our balance sheet as AR Medicaid Pending until such time as outstanding issues are resolved and then are reported as Accounts Receivable – Medicaid until payment is received.
Claims that are accepted by Medicaid are then posted in NH Leads and recorded on our balance sheet as Accounts Receivable – Medicaid until payment is received.

At the end of every month, One Sky records those services delivered that have not yet been billed on our balance sheet as Accrued Revenues Recognized Not Billed Yet since it is assumed that the supporting documentation to allow us to bill for these services has been delayed and will be forthcoming shortly. In addition, a portion of services delivered that have been billed for at an accelerated rate may be recorded on our balance sheet as Deferred Revenues since a portion of the revenue recognized will be used to offset future expenses which we may no longer be able to bill for. The balance in this account is adjusted monthly based on year-to-date activity and every quarter based on the quarterly reconciliation of payments to each Vendor that is completed.

Billing for services payable by the State of New Hampshire utilizing state dollars only are handled by the Accounts Receivable Department. Billings are recorded as Accounts Receivable - State until payment is received.

Billing for all other services provided by One Sky are also handled by the Accounts Receivable Department. Billings are recorded as Accounts Receivable – Other until payment is received.
Specialized (Non-Medicaid) Billing

Focus Area: One Sky Community Services, Finance and Accounting Department

Overview

1. All billing information is forwarded to the Accounts Receivable Specialist for processing.
   a. Billing information is verified for accuracy prior to processing.
   b. Billing information is then entered into the computer.
   c. Computer information is edited and batch is released.
   d. Print two copies of the invoice. One copy is sent to the customer and one copy is filed by name.

2. The Accounts Receivable Specialist keeps an updated list of all invoices that must be billed on a weekly or monthly basis.

Customer Invoice Processing

1. Billing information is verified for accuracy, entered in the computer system, edited, released, and then posted to Accounts Receivable and the General Ledger.

2. Two copies of the invoice are printed. The Accounts Receivable Specialist puts one copy in an envelope and forwards to the mail center for mailing to the customer. The second copy is retained for the company records. Both copies contain supporting backup for each charge.

3. If sending a statement, the Statement Cycle is closed to reflect that the most current information on the statement for the selected customer cycle.
Accounts Receivable Collections

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

1. At month-end close, the A/R Aged Trial Balance Summary report is analyzed for delinquent accounts (over 60 days past due). Coordinators & Account Managers are notified. Statements with notes sent out.
2. Accounts over 90 days past due require collection calls throughout the month and a formal letter. Account Managers are notified to decide who should make the collection call. CFO notified.
3. A monthly report is submitted to the Controller and CFO summarizing all overdue account activity and status.
4. The Controller signs the reconciliation monthly and returns a copy to the Finance and Accounting Department.
Daily Deposits Procedure

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

Cash and checks received by mail will be processed in the following manner:

a. Incoming mail is opened and the receipts are listed/photocopied by a person (the cashier) having no access to accounts receivable or cash receipts records. This person is also prohibited from any access to the general ledger or subsidiary ledger accounts.

b. The listing of mail receipts is subsequently compared to cash receipts posting totals from the accounts receivable system, and to authenticated copies of deposit slips by an employee having no access to the cash receipts.

c. Checks are restrictively endorsed "For deposit only to the account of One Sky Community Services, Inc." upon receipt in the business office.

d. Cash receipts are entered on the accounts receivable cash receipts journal by a person independent of the mail opening and receipts listing functions.

e. Deposits are normally made weekly. Checks and currency in excess of $2,500 or currency in excess of $500 are deposited intact on a daily basis.

f. Adequate physical control over checks and currency is maintained until the receipts are safely deposited in the bank.

g. At the end of each day the receptionist will print two copies of the check register and let the Financial Specialist and AR Specialist know that collections for the day are ready to be transferred from the front desk.

h. They will come to the front desk and initial the yellow copy of the cash receipt book for each cash drop-off of funds to be deposited to their account and take the register page.

i. Each Specialist will reconcile/compare the register with the cash and checks before placing the checks and cash in the safe.

j. Deposits will made, at a minimum, weekly. Anytime cash is over $500 in either account, a deposit will be made the following day.

k. If either of the Specialists are not available, the other will take responsibility for accepting deposits for both accounts or for making a deposit.

l. The Chief Financial Officer will be the backup if neither staff is available.

m. The AP Specialist and HR Administrator will back up the AR Specialist and the Benefits Specialist and Benefits Administrative Support will back up the Financial Specialist.

n. The check register will be reconciled within the first two weeks of the end of each month by the AP Specialist.
Writing Off Old Outstanding Checks

Focus Area:  One Sky Community Services, Finance and Accounting Department

Policy

1. All One Sky checks/all accounts state VOID AFTER 90 DAYS

2. Quarterly process:

   a. List of outstanding checks over 90 days is prepared
   b. Outstanding checks are researched for validity
   c. Stop payment is placed on outstanding check to be voided and reissued
   d. Outstanding checks over 90 days are voided
   e. Replacement check is issued
   f. Letter is sent with replacement check to notify recipient of action taken and that if not cashed within 90 days it will be our understanding that payment was not due and the replacement check will then be voided.
Fixed Asset Acquisition and Disposition

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

The purpose of this policy is to assure that agency funds are used only to purchase those capital items required for the effective operation of the agency. Once purchased, the assets are adequately safeguarded from loss due to fire, theft, or misplacement.

Capital purchases are defined as items having a service life expected to exceed one year, and a cost exceeding $4,000. They normally include land, buildings, leasehold improvements, computers and computer software, machinery, equipment, furniture, and capital maintenance on buildings and grounds. The Board of Directors must specifically approve each capital acquisition in excess of $20,000 prior to purchase, if the item was not included in the approved budget.

a. Capital Budgets: Capital budgets are prepared by Department Heads and the Chief Executive Officer. The capital budget lists the anticipated needs of each department and prioritizes each item. Wherever necessary or helpful, a reason for purchasing the item is provided. The resulting list then becomes part of the state budget submission.

b. Approvals: The Chief Financial Officer is responsible for the approval of fixed asset purchases certification that adequate funds are available for the purchase.

c. Purchase Priorities: The following guidelines determine the order in which capital items are purchased:
   i. Emergency - Any capital items required to address immediate threats to the health or safety of any client, staff member, or other constituent of Region VIII Developmental Services. (Plan, purchase and fund immediately.)
   ii. Urgent - Any capital items which are required by contractual agreement with a funding source. (Plan, purchase and fund as soon as possible, divert funds if necessary.)
   iii. Necessary - Any capital items required by clients or employees to allow the agency to conduct its business in an effective and efficient manner. (Plan and purchase as funds become available.)

d. Additional Procedures: For individual items costing in excess of $30,000 the Chief Financial Officer will conduct sufficiently detailed projected profit and loss and cash flow analysis to determine that revenues from the project will meet or exceed the related expenditures.

e. Annual Review: At least annually, the Chief Financial Officer will require a review of capital items on hand and adjust the fixed asset register/depreciation schedule accordingly. The Chief Financial Officer will determine if the carrying values of the assets are expected to be recoverable in the ordinary activities of the agency. If not, appropriate adjustments are required.

f. Depreciation Expense: The Chief Financial Officer, in consultation with the auditors, determines the useful lives of fixed asset acquisitions and causes the information to be entered on the depreciation schedules.
g. Insurance Coverage: At least annually the Chief Financial Officer will require a review of insurance coverage. The process will include an analysis of the adequacy of insurance coverage on capital assets. Each item purchased during the year will be added to the list of items insured as required by the insurer for immediate coverage.

h. Disposal: The Chief Executive Officer approves the disposal of property and equipment with a residual value of $3,000 or more, based upon the recommendation of the Chief Financial Officer. The Chief Financial Officer approves all other dispositions. Fully depreciated items are maintained on the accounting records until disposition occurs.
Focus Area: One Sky Community Services, Finance and Accounting Department

Policy
1. All Journal Entries are prepared solely by the Finance and Accounting Department.

2. The CFO, Controller, Accounting Supervisor, Assistant Controller or Senior Staff Accountant, must approve all Journal Entries. Any adjustments to Accounts Payable, Accounts Receivable, and/or Cash Management must be approved by the CFO, Controller, Accounting Manager, Assistant Controller, or Senior Staff Accountant.

3. The Journal Entries prepared by the Controller must be approved by the CFO, Accounting Supervisor, Assistant Controller or Senior Staff Accountant.

4. Payroll, Medicaid and State/Federal Developmental Service Funds are entered into the system through a month-end Journal Entry. NOTE: Payroll is the only exception and is entered into the system using the actual pay date. The following spreadsheets exist:
   a. Staff payroll
   b. Consumer payroll
   c. Medicaid revenue
   d. Developmental Services-State/Federal funds

5. Choose General Ledger (from the Main Menu in Microsoft Dynamics for the appropriate company) to enter all Journal Entries.

6. Prior to entering the information, number all journal entries in consecutive order.

7. Enter all journal entries for the current month, edit, release and post to General Ledger.

8. Edit, verify, generate and post recurring journal entries.

9. The following Journal entries are needed on a monthly basis:
   (See Attached Journal Entry Lists)
Closing Procedures

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

The Finance and Accounting Office will email the monthly calendar to One Sky and PLUS Company staff and vendors on the distribution list. The monthly calendar identifies the due dates for the processing of invoices and other financial information.

1. Bank Reconciliations (including adjustments)
2. Close Cash Management
3. Close Accounts Payable
4. Accounts Payable Reconciliation to General
5. Financial Reports
6. Accounts Receivable Billing
7. Accounts Receivable Reconciliation
8. Print and mail customer statements
9. Close Accounts Receivable
10. Close General Ledger
Audit Practices

Focus Area: One Sky Community Services, Finance and Accounting Department

Policy

Annually, One Sky Community Services will have an outside audit completed, as required by contracts with funders. The results of the audit will be presented to each Board for review and action.

One Sky will place its audit business out to bid every five years. The One Sky Finance Committee will oversee the bidding process and recommend a new auditing firm to each Board for their approval.
Billing Instructions
Utilized by East Coast Reimbursement Services
For
One Sky Community Services
(October 4, 2019)

Contents
CONTACTS........................................................................................................... 77
CONDUENT/MMIS Information (Formerly Xerox) ......................................................... 79
MEDICAID ELIGIBILITY............................................................................................... 82
TIPS................................................................................................................................. 83
INTAKE USE .............................................................................................................. 84
  How to Use Intake to Enter a Missing Medicaid ID# ................................................. 84
  How to Use Intake to View A Diagnosis ................................................................... 84
  How to Use Intake to View/Correct Rep Payee or Assignment of Benefits or Release Forms ................................................................. 84
  How to Use Intake to View Anything Regarding Missing Intake Information ........... 85
HOW TO RUN REPORTS ............................................................................................ 86
  How to Run Pending Report ....................................................................................... 86
  How to Run Denied Report ........................................................................................ 86
  How to Run Client History of Services .................................................................... 86
  How to Run Claims by Status .................................................................................... 86
  How to Run Attendance and View Who Entered it .................................................... 87
  How to Run Report to View Claims by Status ............................................................ 87
  How To Run Report for Cost of Care ....................................................................... 87
  How to Run a Report by GL? ..................................................................................... 87
  Reports to Run Weekly and Work ............................................................................ 89
CLAIMS ......................................................................................................................... 90
  Note about Claims ..................................................................................................... 90
  How to Rebill a Claim ............................................................................................... 90
  How to Write off a Claim ......................................................................................... 90
  How to Void a Claim ............................................................................................... 90
  How to Recoup a Claim ........................................................................................... 91
GL CODES AND COST CENTERS AND CONSUMER PLACEMENT ......................... 92
To View Consumer Placement ................................................................. 92
How to Enter a Consumer Placement .................................................. 92
How to Edit or Modify Consumer Placement ....................................... 93
How to View/Edit/ADD Vendor to Master ........................................... 93
PRIOR AUTHORIZATIONS ..................................................................... 94
A note about PA’s .................................................................................. 94
ATTENDANCE ........................................................................................... 97
General Notes Regarding Attendance ................................................. 97
How to Enter Day Hab Attendance (CPS type Service) ....................... 98
Notes on Day Hab Services ................................................................. 98
How to enter SEP (Supported Employment) CPS type Service ............ 99
Notes on SEP ....................................................................................... 99
How to Enter Community Support Services/CSS Attendance (CPS type Service) ........................................................ 100
Notes regarding CSS services .............................................................. 100
How to enter CRRS (Crisis) (CPS type of service) .............................. 101
Notes on Crisis .................................................................................... 101
How to enter Residential (CPS type of service) .................................. 102
Notes on Residential Services ........................................................... 102
How to Enter CM Attendance ............................................................. 103
How to Add a CM to the Log or Delete Someone Permanently .......... 104
Notes on CM Billing ............................................................................ 105
How to Enter Attendance for EI (Early Intervention) Ritchie McFarland (RMCC) and Waypoint (formerly Child and Family Services) ........................................................................ 106
How to enter the EI CM ...................................................................... 106
How to enter the Evaluations .............................................................. 106
How to Enter the EIB Services ............................................................ 106
How to enter IHS (In House Support) .................................................. 109
Notes on IHS ....................................................................................... 109
How to Enter CDS/PDMS Attendance ................................................ 110
Notes on CDS/PDMS ........................................................................... 110
How to Enter Home Modification /EMOD Billing ............................... 111
Notes regarding EMOD ....................................................................... 111
How to Enter Specialty Services/SSL /SIS and HRST Attendance ........ 111
Notes regarding HRST, SIS and Specialty Services ............................ 113
CONTACTS

One Sky 603-436-6111
One Sky E Fax 603-436-4622

BDS-PA-Michelle Rosado 603-271-5154  Michelle.Rosado@dhhs.nh.gov
Michelle Fax# 603-271-5166
105 Pleasant St. Concord, NH 03301
BDS-PA’s older issues –Reba 603-271-5019- Works for Michelle

BDS-DHS-Eligibility issues and Cost of Care—no contact anymore
BDS-HCBC-271-5149 (not sure Anna Morales) call Joanna first then Reba
BDS-271-5032-Do Not Call -Darlene Ferguson- Never call Manager of all
MMIS issues- 223-4702. (Used to be Nancy S. she quit 2018)
Also, Field Rep that helped claims Manager, Alyssa.Stephenson@conduent.com (2018)

Conduent issues-223-3096-Contact Mark AAronbers (this was 2017 not certain)
CSNI-Leads 319-4785 -Contact Cris Philipson
Client Services-don’t call unless necessary they will forward you to BDS. 271-9700 #4
TPL-Third Party Unit-603-271-8887 Fax # 603-271-5116
Conduent-866-291-1674-phone PIN DD only 515190
FYI Link to State RSA 171- http://www.gencourt.state.nh.us/rsa/htm//xii171-a/171-a-mrg.htm
FYI, He-M 500 Regs link may not work, need to see HE-M 517 regs should be gencourt statehouse
To find General Medicaid Manual Vol 1-Go to MMIS prior to signing in -Provider Tab (top)
Billing Manuals-dated 121718 General. Also, No Volume II yet
CONDUENT/MMIS Information (Formerly Xerox)

https://nhmmis.nh.gov/portals/wps/portal/provider login for MMIS

https://nhleads.org/default.asp

**PROVIDER #'S and Info for Conduent**

<table>
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<tr>
<th>Provider</th>
<th>Number</th>
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<td>020368955</td>
</tr>
<tr>
<td>NPI#</td>
<td>1568512770</td>
</tr>
</tbody>
</table>

DD phone Pin# 515197 (092619) ECRS Manages these. Always update spreadsheet in ECRS and inform all any changes. (Need pins for all 5 provider#)

Conduent Claims Unit  
NHPDproviderrealations@Coduent.com  
PO BOX 2003  
Concord NH 03302-2003  
1-866-291-1674

**Appeals** – Same address just write ATTN: Appeals. Also, all requests for a review should go here first even if you are well beyond 12 months filing. Always attach the Override Request Form, provide clean 1500 and the RA and or letter of review request.

**Grievance** – Same address. Write ATTN: Grievance (Only send to this department if claims are more than 2 years old.) OR Extreme cases with no response from Appeals Try Grievance

**Prior Authorizations** – Same address. Put ATTN: Authorization Dept. (Only Original PA requests and Renewals go here

Encrypt files -always use Region8 password for DHHS
Continued MMIS Information

Rules:

*1-year Timely Filing limit - all must go to Reba at BDS 1st with letter, she sends to Conduent 10/18
*If denied you have 6 months from denial date. (Call to be sure) Used to be 1 year from payment or denial date. Once you have corrected the problem you can simply resubmit the claim if under 12 Months.
*If Client had updated eligibility, you only have 6 months from updated eligibility date if beyond 1 year to send an original claim. (Must use Override request form follow instructions)
*If you missed the 12 months timely filing, you have up to 15 months to resubmit with Override request form but again, you should try an appeal if you miss this 15 months’ limit too. They may take your appeal letter into consideration. They have in the past. (again, this changed must go to Reba first for PA issue)

*For PA requests they will only go back 120 days if you failed to request one
*For PA Renewals - They are supposed to be requested 45 days in advance
*For Eligibility issues, if the client never reapplied, once they do reapply, DHS will only go back 90 days - If they had requested retro-eligibility.
*Upload all 837 by Thursday 4PM. You can sometimes try up to 11 Am Fridays
*All 835 Download on Friday mornings
*TCN - The 6th digit of the TCN can be this: 1=Web based, 2=Xover claim, 3=Clearing house or Vendor Electronic, this would be One sky 837, 4=Paper on system, 5 and 6 not sure, and 7=Paper claim (so for us, we would see 3 and 7.)
*NHHPP - (Also NHHPP becoming Granite Advantage 1/19) Currently there is an issue with this default Medicaid coverage. NHHPP is when a client turns 19. They sometimes automatically go on this to avoid losing coverage if they have not signed up for Medicaid. If they have not applied for APTD then nothing is covered. Also NCCW is a covered service for anyone having Medicaid. YOU DO NOT require Disability coverage BUT with NHHPP they deny claims. BDS aware (April 2017) stated it is being looked at.
*Also, re: Granite state advantage Karen mentioned Medically Frail for FSNCCW?
*EIB - Early Intervention Services - Generally 3 years and younger also need just Medicaid to be covered. Do not need disability elig.
ALL Other DD services require a Disability Determination coverage stated along with the Medicaid.

DD - HCBC or DD - Acquired Brain Disorder (ABD) Also I.HS (In home services) - PDMS
*Per Reba at BDS on 090319 - There are times that a DD person may have a spenddown not a COC it is rare and usually means too much money. So they do put the HCBC on but unless someone opens this Client each month it is a problem
MEDICAID ELIGIBILITY

To view a client’s Medicaid eligibility—log onto MMIS.  
https://nhmmis.nh.gov/portals/wps/portal/provider
Click Provider login (on right hand side)
Enter your User ID and password
Click Member (on top Bar)
Click Check Eligibility
Enter 3 Criteria and Date range (1 year at a time) Spelling matters. Look at Eligibility Status: It should state “Medicaid “up to the current date (or up to date you need)
Look at Plan Description: It should state “Medicaid” up to the current date and it must say Special Eligibility such as HCBC or ABD etc. up to the current date. (Unless EI Services)

Notes about Eligibility:

If Under the “plan Description” it does not state Medicaid, this is a problem. No Managed Care covers DD, nor does NHHPP. (unless they have APDT also changing to Granit advantage 1/19)
All DD billing (other than EI Services or children) must have a Special Eligibility code. If not that is also a problem.
If you cannot pull up a client in MMIS- call Conduent. Customer Service will help.
If you have eligibility issues, contact the Service Coordinator and CC SC Manger and also CC Denise Larson, the benefits specialist at One Sky.
You can also go directly to DHHS Eligibility, currently no one took Joanna’s place
If there are Issues with the “Special Eligibility” After DHHS confirms it is not a paperwork issue on their end the next step is to reach out to BDS Ann M. or Reba to ask if they can add the code back on. 603-271-5154 or Contact through estudio currently the best method of communication with them.
*One Sky should be using NH Easy, Especially the complicated Cases. They must sign form 11. This gives One Sky permission to access NH Easy. If Form 11 is signed it goes to one designated person’s dashboard. Anyone with this dashboard can upload documents or elig re-applications or view status of elig or rejections notices. Any Medicaid ID corrections that Billing finds should be fixed in Intake but also communicated to appropriated staff that handles the other system.
TIPS

To View Attendance in One Sky
Go to Y
CM
  Attendance - Year-Month-Vendor
*2019 this is outdated-now use Ebridge software-need user name, view by Vendor and Date range

To View where Vendor List is in One Sky
Common X
  Everyone Folder
  Provider Choice

To View BTS

To View Paws Tracking

To View Client by Vendor

To View PA DEPT Spreadsheet Master
  Y
  Business
  Pending
  FY17 or Y18
  Most recent date

To View PA Renewals and Tracking
  Y
  Business
  Prior Authorizations folder
INTAKE USE

How to Use Intake to Enter a Missing Medicaid ID#

Intake is generally for reference only for the Billing Dept.
In NH Leads
Intake
Consumer
Search
By Last name or Duck #
Double click client
You can enter a Medicaid ID here if missing
Click Save

How to Use Intake to View A Diagnosis

NH Leads
Intake
Consumer
Search
By Last name or Duck #
Double click client
Click Intake again, upper left corner
Click Consumer Diagnostics on drop down
Click on Diagnostics Information Box that appears.
Next screen you can View Diagnosis. Use Scroll Bar to go left and right ICD10 starts 10/01/15
All Diagnosis should have Rank 1 for primary. All ICD10 should have end date. Computer automatically puts 10/1/2115.

Never make a change to Diagnosis. Tina or Intake must be emailed to make this change.

How to Use Intake to View/Correct Rep Payee or Assignment of Benefits or Release Forms

NH Leads
Intake
Consumer
Search
By last name or Duck #
Double Click client
Intake
Click Billing Release in drop down menu
On 1st option check 2nd drop down box (Cris P said on 09/17 you should pick “last choice”
On 2nd option check 1st drop down box
Check Assignment Yes
Billing should use this as view only and request Tina the Front Desk Manager to make these changes.

How to Use Intake to View Anything Regarding Missing Intake Information

NH Leads
Intake
Consumer
Search
By Last name or Duck#
Double click client
Intake upper left
Look at drop down menu.
All changes to Intake should be done by Tina the Front Desk Manager

FYI-As of 2019 Stephanie Auclair handles Intake issues
HOW TO RUN REPORTS

How to Run Pending Report

NH Leads
Service Capture
Reports
Services Billing
Pending Services by Consumer and Service level
DO NOT enter region 8 (flaw)
Click Submit
(Or enter criteria of your choice)

How to Run Denied Report

NH Leads
Service Capture
Reports
Report Wizard
Function area should be all
Find Denied Claims by Consumer on right side
Hit Next
PUT REGION 8!
Click Submit

How to Run Client History of Services

NH Leads
Service Capture
Reports
Report Wizard
Function Area should be all
Find Consumer History by Service Level
Next
You can enter Date Range or other criteria
Submit

How to Run Claims by Status

NH Leads
Service Capture
Report
Report Wizard
Claims Status upper left-Select which report you want //then Region 8// then on right side select Claims by Status//Next-Date Range //and Submit

How to Run Attendance and View Who Entered it

NH Leads
Service Capture
Reports
Report Wizard
Function Area should be all
Find Attendance List by Consumer
Select all criteria you want
Submit

How to Run Report to View Claims by Status

NH Leads
Service Capture
Reports
Report Wizard
Functional Area should be all
Find Claims by Status
Select all criteria you want
Submit

How To Run Report for Cost of Care

NH Leads
Service Capture
Reports
Report Wizard
Cost of Care Xerox (with GL)
Run by GL transaction date or Check deposit date or service date
It will list claims that had some activity with COC as determined by reason on RA
Send to Brandie and Brian at end of each month.

How to Run a Report by GL?

Select Claims and Adj Cost Center Contiguous
Or Select claims and Adj by Cost Center and Date
Had this noted that I ran this for Vin once, 2019
Reports to Run Weekly and Work

Pending Report
Following the instructions in how to run for pending, you should run the pending each week after validation and work it.
Many Errors are simple fixes. Medicaid ID’s missing, Assignment Form Missing, Diagnosis missing, no GL code, and Insufficient PA dollars. The major reason held up on Pending is PA missing. You must work with the PA specialist to make sure all is in process.
All errors require a bit of research. Once the error is corrected in the appropriate place these claims will process the next time you validate claims.
If you must delete something off Pending, you must go into the Attendance and delete from there.

Denied Report
Following the instructions on how to run reports for Denied you should run it each week after posting the weekly 835.
Typical Errors, are no Medicaid, No special eligibility, no Pa (most likely due to UCR) cost of Care, Timely filing etc.
All Denials require research. Once corrected you must go to the claims file and resubmit the claim, or write off, void etc. All claims should have a note written on the actual claim when you do fix and take action.
Any questions on denied contact Conduent, sometimes denial reason is NOT what it says on report.

837 Error Report
Refer to 837 Instructions on how and why

Batched Claims Report
Following the Instructions on how to run Reports for claims status you should run the batched claim report each week after posting cash. Watch dates. The date range you select is critical.
You want to be sure NOT to include dates of service that are still pending at MMIS. Thus, I usually select dates going back to July 1st of the previous fiscal year up to the date before you last validated.
The purpose of this is to show you problems. Claims should never be in batch mode for more than a week or so. If they are there are problems you must correct.
Some examples of Batched issues: Cash was posted too soon (without waiting a ½ hour after importing thus not all denials will post. Or, they rejected at MMIS. Or someone could have changed a PA while in the middle of processing/validation the claims. All require research. Most likely once issue is determined you will need to Contact CSNI for help reprocessing those claims stuck in Batch mode.
CLAIMS

Note about Claims

Once Attendance is validated it creates a claim. From here on in you must work the date of service in the claim area. It is always assigned a Claim number. You can view this number at the bottom of a selected claim screen. It also provides dates of RA postings with information and status of claim with dates. Also at bottom of claim screen when you click the status date if there were any notes input at time of resubmission or write off etc. The notes appear here. Other valuable information is here also, GL code, units, $ value etc.

To Get to Claims
NH Leads
Service Capture
Claims
Disposition
Claim Search click
Generally, Use the 2nd option “Detail Search”
Hover over transparent box
Search by Name or Duck
When List appears-select client-then OK
On left Side select criteria to bring up this claim such as Denied claims/or date/ or whatever and search
When List of claims appears, select your claim by double clicking

How to Rebill a Claim
Using above Instructions
Rebill
Put status note on why you are rebilling
Save

How to Write off a Claim
Using above Instructions
Click Write off
Enter proper GL Date
Write status note as to why you are writing off

How to Void a Claim
Using above Instructions
Click Void
Enter proper GL Date
Write status Note why you are voiding this claim
VOIDS ARE PERMANENT. YOU CAN NOT REVERSE. YOU SHOULD USE SPARINGLY. YOU MUST RE-ENTER ATTENDANCE IF IT WAS AN ERROR

How to Recoup a Claim

(Follow all steps in how to rebill a claim except ….)
Click Recoup
Enter Proper GL Date
Always put Status Note as to why you are sending Recoup
GL CODES AND COST CENTERS AND CONSUMER PLACEMENT

A Note about Cost Centers ---Only BTS group creates these.
A Note about Consumer Placement---Billing will be entering, or modifying these as well as the PA person and BTS group. Always understand what you are doing if creating a missing consumer placement or amending these. They go hand in hand with Authorizations and the BTS budget. End dates are in theory placed there deliberately to suggest the client may no longer has the service. Always research prior to making any changes.
*Flaw-if you create a new Consumer placement it is not reversible. At best, you can only end date it the same date as start date. On rare occasion CSNI will delete it.
*If a consumer placement is changed it will affect any attendance in process and the claim area as well. If a claim is attached to the placement that you are changing and you are trying to write it off for example an error will pop up. Much thought must go into this before changing.
*If you try to delete attendance and cannot bring it up due to cost center it may be this: The Vendor was not assigned to One sky. To assign: Administration/Service Providers/Filter/Search/Click add to RG8
I would not do this however without Finance Manager or someone’s permission. They must have deleted it for a reason

To View Consumer Placement

NH Leads
Service Capture
Administration
Consumer Placement
List (this bring up everyone)
Filter
Enter Last Name
Ok
This brings up everyone with that last name. Be sure to view only your client and note that there could be more clients on the next page. (This is a flaw in leads if you do not see your client be sure there is not a second page.)

WITH KNOWLEDGE AND PERMISSION PROCEED TO NEXT STEP

How to Enter a Consumer Placement

(Follow above steps)
Click New
Search Client by last name
Click the client when name appears
Click OK
Service Level -you must be positive Do research first
Service Provide-you must be positive-hint One sky is being used as a default to many vendors but the GL code will always be accurate
Start Date-Enter
End Date leave blank
GL Cost Center Code-Know this-be absolute Most important criteria refer to listings
GL Cost Center-is the Cost Center Code with 3 zeros at end

How to Edit or Modify Consumer Placement

(Follow above steps on How to enter GL code)
Click the client and placement you want to modify
Click Modify
You can only modify dates or GL Codes (not the service code)

How to View/Edit/ADD Vendor to Master

On rare occasion, if you are entering attendance or deleting attendance and the GL does not pop up in the drop-down section. It could be that the vendor is no longer assigned to region 8. Go to:

Service Coordination
Administration
Service Provider
Filter Search “starts with”
Click add to AA8 Button
PRIOR AUTHORIZATIONS

A note about PA’s

Refer to PA dept. policy, updated 2019
PA’S 1 YEAR AGREEMENTS. CHANGES SHOULD ONLY BE FOR A CRISIS
PA’S SHOULD BE RENEWED 60-90 DAYS IN ADVANCE
YOU ONLY HAVE 60 DAYS TO DO A Request FOR A PA
YOU ONLY HAVE 120 DAYS TO REQUEST A PA CHANGE
ONE SKY Changed POLICY. FROM NOW ON CHANGES SHOULD ONLY COME UP ON
THE RENEWAL DATE NOT WHENEVER THEY WANT. (2018?)
CHRIS AND CFO SIGN OFF ON CHANGES, IT GOES TO BILL. HE UPDATES BTS-
UPLOADS TO BDS
D. FERGUSON AT BDS REVIEWS AND EITHER APPROVES OR REJECTS OR
CHANGES.
WHEN BILL SENDS TO BTS HE SENDS OUT EMAIL-WE SHOULD BE INCLUDED
ROCCO (CFO) wants ECRS to add GL codes for Paws changes.
IF BDS SAYS YES, change PRE-APPROVED THEN ONE-SKY OFFICIALLY REQUESTS
PA. UCR GOES TO DIVISION.
WHEN BDS APPROVES the UCR (UCR=UNITS CHANGE REQUESTS FORM)-PA dept.
Sends out email to ECRS and ATTENDANCE SHEETS CAN be entered again/reviewed
by ECRS/run unbillable etc.
-As of 2019 PA dept. will not update Paws for a UCR until UCR is approved. That means much
thought is given on how to handle UCR attendance. At times it can be added, put on hold, it may
go to unbillable and now the GL code may be ended to get these claims to hang up on the denied
report.

PA Dept. KEEPS LIST OF PA CHANGES, VITAL FOR BILLING
ALL PA’S IN PAWS
REBA/Michelle ENTERS PA# into MMIS
IF PA is INCORRECT CONTACT REBA/Michelle FOR CORRECTIONS. Review this FIRST
YOU CAN RUN PA UNITS used report: LOOK UP IN SERVICE CAPTURE-REPORTS-
SERVICE CAPTURE- Billing/Admin-PA units usage report.
WE TEND TO OVER PROVIDE, ONCE CONFIRMED IT’S A WRITE OFF unless it went to
unbillables.
IF PA ENDS BEFORE FISCAL YEAR 2016 PER ROCCO (CFO) DO NOT PURSUE, WRITE
OFF DUE TO RECOUP PROJECT AND RE-ALLOCATION PROJECT
PAWS ONLY WORKS ON WINDOWS 9 OR BELOW-NH Leads issue
FOR HISTORY REFERENCE: IN THE PAST HP (former Medicaid Contractor) ENTERED
AND TRACKED PA’S IN PAWS, NOT WITH XEROX, IT IS UP TO ONE-SKY TO
MAINTAIN PAWS.
WHEN CHANGE HAPPENS to service codes-TERM OLD PLACEMENT, ENTER NEW
CODES
RESIDENTIAL AND DAY PROGRAMS ARE CONSIDERED ACCELERATED. WHAT
THIS MEANS IS: BASED ON 365 DAYS, (PA IS) IF THE CLIENT ENDS THE PROGRAM
BEFORE 12 MONTHS AND YOU HAVE USED UP ALL THE UNITS, YOU MAY HAVE TO SEND A RC. BILL WILL NOTIFY US. (ANOTHER WORDS, YOU COULD HAVE MET ALL UNITS IN OCTOBER AND NOVEMBER AND DECEMBER GO TO UNBILLABLE BUT BILL WOULD DO THE MATH, CALCULATE OUT $ AMOUNT OR UNITS ON PA. DIVIDE BY 12. AND CALCULATE HOW MANY UNITS TO REFUND TO MCD.)

When checking issue, make certain it is not an HCBC issue first.

To preview a PA, “preview” then OK, then print it gives you a copy of what actually goes to MMIS

To view Bills hold list, go to Y, Business, CFT Pending change, Pa’s scanned Y, Business, PA scanning

Continued-PA information

CONTINUE-PA

Function screen is only good for 1 year-Also known as FST and there are written instructions on this

When entering DH6 or SEP3 for 1st time or rate change you must contact Cris at CSNI of the rate. She has to add it to the file, otherwise the entire billing file will fail. Give her Duck#, code and rate and effective date-This also applies to a “change” to those code.

Brian G. currently adds and changes all Prior auths. Crucial for billing to work with him. If he has not yet entered a PA or UCR change it will affect billing and could potentially wreak havoc on UCR approvals.

To Enter a PA

Paws Application
New
Enter clients, dates
Service detail on left Click NEW
Add code, Service Detail, provider, cap units, amounts (no commas) Again, consult with Dan, this is only FYI. Also, CDS provider # in paws is HE M525
If you were to send out a PA, you can go into Preview, click applications edit, put your name and now your name appears on the PA going to bds. FYI only, do not do this

Per Reba, on initial HCBD only she and Michelle do this. Must send Pa request first, if approved they add HCBC.

Problem when changing units of $ value for day or residential. You can’t change, you literally must delete the old code/units and add new one in
Use 9999 and $99999.00 for some codes

As of 04/01/18 Per Reba
For any HCBC issues or any special eligibility issues upload a spreadsheet to E studio, under the PA sections, “other” folder. Put name, Medicaid ID, Date. Sent Attn: to Reba and Ana Morais
ATTENDANCE

There are 4 ways to enter Attendance in Service Capture in NH Leads

General Attendance
Early Intervention Evaluations
Environmental Modification
Case Management

General Notes Regarding Attendance

*About 18 plus Vendors submit to One Sky should be 1st-15th, then 16th-31st unless monthly
*One Sky Enters Attendance as often as possible, heavy weeks are every other Month. The end the most.
*One Sky Bills Medicaid
*One Sky Pays Vendors
*Currently Attendance may be uploaded directly to Ebridge by Vendor or placed in ECRS
Attendance to be entered folder.
*Prior to entering attendance-Organize. Watch months, Watch for signatures, watch for amended, also per Tina must be a handwritten signature. Not signed electronically. Nothing typed. 11/9/18
*Watch for types of service
*Vacation billable with provider see 092618 email. Provider should be listed
*Respite billable with cert number for RES
*Never bill for Hospital
*Ritchie McFarland always GL E24000 and Child and Family E20000 The GL’s are often missing, go ahead and add them as these are young children
* Each year Accounting sends notice to stop billing for year-budget hits a max. With permission BDS will allow so many more units to be billed for the FY but they notify CFO of units allowed.
*Once attendance is validated it becomes a claim. You can no longer correct any issues in the Attendance area. It must be done through Claims. (Void etc.)
*If you make an error and you have NOT validated yet, you can simply re-enter the criteria, click Generate Calendar. Each date will have a pencil mark. Click each box you want to fix and hit the DELETE button. Click Save. Now go back and re-enter it correctly. You can just delete one date if you need to. But if you want to delete the whole month, you have to click each and every date and the delete button.
*If the attendance hangs Hit reset. More often you will have to get all the way out of leads and get back in, there are some system flaws.
*Validate often. If you are entering lots of billing such as at month end, again, there are flaws, it may be best to stop and validate and create claims at least once or twice depending on the amount being entered to avoid any issues.
*Service Levels -Should always appear in bold. If not, stop! Most likely a PA issue. Investigate PA and read notes, Check BTS, Paws Change forms, Cost Center, client history to find correct service to enter. Never guess. **BOLD** means that there is a current PA on file. (Or at least a UCR
in process) Of course some codes will never appear in bold, such as Non Medicaid billing and EI services since no PA is required

**Continued-General Notes for Attendance**

*Service Provider. One should populate for that code if there is one on file. Refer to GL Cost center list to double check its correct vendor. If no GL cost Center appears, STOP! This is a problem. Do your research, contact BTS group, or look at recent Paws change forms, and contact SC Manger. Before entering the service to find out what is going on. There is most likely a reason why there is not a code entered.

*For Rate box: do nothing unless there is a problem you are aware of and you must manually enter a rate (for example, a PA change not entered yet for a DH6 or SEP3)

*You should bill NDH codes_ Non Medicaid NCCW, NCCWR NHD etc

**How to Enter Day Hab Attendance (CPS type Service)**

**NH Leads**

- Service Capture
- Service Capture again
- General Attendance

1. Start Date and End Date: Be consistent. Enter the 1st thru 15th or the 16th to end of Month. UNLESS it is a Monthly billing such as 521 (If you do not follow this rule it can create issues)

2. Search for the Consumer

3. Select Correct Bold Service Level

4. Select Correct Service Provider

5. If all information looks correct click Generate Calendar.

7. For Day Attendance: 24 Units automatically populate each date on the Calendar except Saturdays and Sundays. If they were seen they typical get 24 each weekday you can simply click save, if not carefully change each date to the correct number of units.

8. SAVE (upper left)

**Notes on Day Hab Services**

*Day Hab is billed in Units. 15 minutes units

*Observe low units. While some clients may have low, most clients will have 12-24 units. Be certain attendance was submitted with Units, not hours.

*DH1, DH2, DH3, DH4, DH5 and DH6 are the codes (as well as ABDDH etc)

*DH6 –For Initial PA’s or UCR’s using this code, you must contact Cris Philipson at CSNI to enter the rate! It will cause the billing to crash, you will not be able to generate billing if this was not done. She adds the rate. Again, first time only using the DH6. (or change) To get the rate,
refer to BTS, Paws change form or take $$ on the PA divide it by units. The rate approved for each unit is what Chris needs.
*Just FYI CPS and SEP client can have both, usually PA # for each. Sometimes Sep can be under umbrella of SEP, not clear on this.
*Attendance should always be submitted even if a zero and entered
*V for vacation is billable with provider, they should put the provider’s name on sheet

How to enter SEP (Supported Employment) CPS type Service

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date: Be consistent. Enter the 1st thru 15th or the 16th to end of Month UNLESS it is a Monthly billing such as 521 (If you do not follow this rule it can create issues)
2. Search for the Consumer
3. Select Correct Bold Service Level
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
7. For SEP Attendance: 24 Units automatically populate each date on the Calendar except Saturdays and Sundays. Be very careful to change each date or make zero, otherwise you would be overbilling. (Unless each date was the 24)
8. SAVE (upper left)

Notes on SEP

*There are 3 codes on the BDS List
*Clients can have SEP and Dayhab should have PA# for both, occasionally SEP can be under Day umbrella not clear on this.
*Sep billed in 15 minute units
SEP3 rate original billing must be sent to Cris at CSNI or change in rate. Otherwise billing file crashes.
How to Enter Community Support Services/CSS Attendance (CPS type Service)

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date: Be consistent. Enter the 1st thru 15th or the 16th to end of Month. UNLESS it is a Monthly billing such as 521 CSS IS MOSTLY SUBMITTED MONTHLY
2. Search for the Consumer
3. Select Correct Bold Service Level
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
6. CSS You must enter units, all dates come up as zero
7. SAVE (upper left)

Notes regarding CSS services

*There are 2 codes for CSS on BDS report
*CSS is billed in 15 minute units
How to enter CRRS (Crisis) (CPS type of service)

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date: Be consistent. Enter the 1st thru 15th or the 16th to end of Month UNLESS it is a Monthly billing such as 521
2. Search for the Consumer
3. Select Correct Bold Service Level
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
6. CRRS You must enter units, all dates come up as zero
7. SAVE (upper left)

Notes on Crisis

*There is only 1 Crisis code on BDS sheet
*Crisis is billed in 15 minutes units.
*The Maximum crisis you can bill per day is 96 (4x24=96) NH Leads will let you enter more but will then Have an error.
*on 061219-Per Darlene Ferguson at state, she stated in certain situations billing for crisis can be submitted as crisis OR CPS. Depends on what PA is. (for example we had attendance stating crisis but PA was for CPS we were told for this particular client bill it as CPS do not bother getting change of attendance sheet*
How to enter Residential (CPS type of service)

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date: Be consistent. Enter the 1st thru 15th or the 16th to end of Month. UNLESS it is a Monthly billing such as 521 (If you do not follow this rule it can create issues)
2. Search for the Consumer
3. Select Correct Bold Service Level
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
6. For Residential Attendance: Check marks automatically populate each date. If the client was P for present on each date then simply click save (upper left) if client was absent for residential you must select absent from the dropdown and a reason. If they were on Respite select R UNLESS that date was CERTIFIED (it should state this on Attendance sheet) then you can bill for being present. It will be a billable service.
8. SAVE (upper left)
9. Tip for any DH6 or SEP3 individual rate you have to email Cris at CSNI for 1st time code used or a change in rate for these codes. Tell her client, rate, effective date

Notes on Residential Services

*Residential is a 365 Day Program
*Residential is billed per day
*You can never bill for Respite care (RESP) when a person is receiving Residential services
*RPCLEV1, RPCLEV2, RPCLEV3, RPCLEV4, RPCLEV5, RPCLEV6 are the codes. Units are per day
*Per Bill you can’t have CSS with RES? 2019 (not positive if he meant Respite? Need to look into)
*Vacation billable with Provider only, should have name etc. double check
How to Enter CM Attendance

NH Leads
Service Capture
Case Management
Case Management Log
Click Correct Group Name: Currently using only RMCC-EINCCW, FS-FC A-L, FS-FC M-Z, Waypoint EINCCW and REG CCW-CM
Service Date-always use the last date of the month you are billing
Locate clients name and to the far right click the Contact Box. Make sure there is a GL code. If not STOP! Research and add one.
Click Save upper left hand.

*If you need to delete a CM from log, simply bring up the same date, and uncheck the contact box and save. (If it has not been validated yet)
*Enter many at the same time. Save often. It is common to lose clients if not saved frequently
*The below was from Michelle Rosado on 030619 regarding what date of service to bill CM. Her response was it is OK to bill last date of month.

“Sorry for the delay in responding I had to speak with our Finance Administrator regarding your question. Additionally, you may already have this information as I spoke with Fran by phone this morning

Waiver Case Management is a monthly billing 1 unit/$257.35. Typically, most area agencies bill this service on the day of the month as several contacts may be made throughout the month to the individual. However, there is nothing that prohibits the agency from billing on an actual date of service that a case management contact has been made. All documentation for the service shall be maintained by the agency in accordance with the regulation(s) outlined in the rule(s). BDS
has not given a directive on when agencies choose to bill case management services, the decision remains with the agency.

Please let me know if you have additional questions.
Thank you
Michelle"

How to Add a CM to the Log or Delete Someone Permanently

Often a client will not be in the CM Log. If this is the case, you must add them (could have changed from another group, or new client) Always, confirm with SC Manager to be certain of what type of CM and what group prior to adding.

NH Leads
Service Capture
Case Management
Administration
By Member
Filter
Search for your client
*If the client shows up, select the client and click MODIFY.
Change the Current CM group to the correct one, Change Current Service Level to correct one and save
*If the client is not in the system Click NEW. Add the client, Current CM group and Current Service Level and save. (Most likely if you added a new one you may also have to add a GL code)

To Delete someone from the CM GROUP entirely, make certain there is no outstanding billing, then go to CM, Administration, By Member, search for client then select Delete. This should be done when someone changes regions, or ends services with One Sky.
Notes on CM Billing

It is difficult to locate Reimbursement rules in writing from BDS on DD Billing. The below is general information. FYI

Currently we have 4 Lists submitted each month.
1. Adult- SC In-house vendor submitted by Karen M. SC Manager
   REG-CCW. Codes will be CM, ABDCM, CMADV, and NXIX
2. Child and Family In House Vendor submitted by Karen M SC Manager
   FS-FC A-L and FS-FC M-Z. Codes will be FSNCCW and FSNXIX
3. Ritchie McFarland-Submitted by the Vendor
   Codes are RMCC-EINCCW
4. Waypoint-Submitted by Vendor
   Codes are CFS-EINCCW (formerly waypoint was CFS)

*CM =*
*NXIX= 0 $*
*CMADV=higher $ (note: as of 010118 Code no longer to be used as well as ABDCMADV)

*CCW=Billable
*FSNCCW=Billable
*NXIX-Non Billable
*NCCW=Non Billable

*CM billed as 1 per month
*Targeted CM=NCCW =No PA required Also, Not currently covered under NHHPP
*EINCCW-No PA required
*NXIX-means they do not have Medicaid but we must enter to track
*Email sent out by Rocco 12/28/16 to Karen:
Break attendance into 3 groups.CM, CMADV, NXIX. No PDMS should be on CM sheet, or HIS
*S01-Gl code Adult
*F02-GL code Child
*E20-GL code Waypoint
*E25-GL code Ritchie McFarland

*You can’t bill for CM when someone has Respite (or is it FSNCCW?)
*FSNCCW is supposed to be a CM for a client that does not qualify yet for DD services so you should not be billing this when there is a PA. MCD will pay, they have a system flaw.
*IHS SC is submitted with the IHS Attendance and the only SC NOT done thru CM Log. Code is IHS PDM FSSC
*Every 3 months Karen and Brandie send missing CM list. You must research why not entered, also they have a flawed report that does not necessarily show what is really missing, again no way know except researching for them.*
*ib 012819 in email Lenore confirmed that can client cannot have NCCW/FSNCCW with Respite because one states non Medicaid and one says DD elig

How to Enter Attendance for EI (Early Intervention) Ritchie McFarland (RMCC) and Waypoint (formerly Child and Family Services)

How to enter the EI CM

See notes on how to enter CM. Go to CM Log it will be RMCC-EINCCW or Waypoint- EINCCW

How to enter the Evaluations

NH Leads
Service Capture
Early Intervention
Date of Service
Select Consumer
Select Service-We are only billing EIASSESS
Select Provider
Consumer Placement should populate on upper right side, if not add one
On Bottom of screen at EVALUATIONS-click NEW
It self populates the date of service you selected above
Click Save

How to Enter the EIB Services

NH Leads
Service Capture
Service Capture again
General Attendance
1. Start Date and End Date-always enter full month range
2. Search for the Consumer
3. Select Service code EIB (it will never be bold-no PA required)
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
6. Check each date that EIB was serviced on
7. SAVE (upper left)

Notes on RMCC and Waypoint

*Warning: Ritchie McFarland and Waypoint submit their Service Coordination attendance on the same sheet as 2 other billable codes. So total of 3 codes may be billed.
*RMCC-be sure to look at the SC Date column, again only bill those with a date and only use the month end date for billing! Also remember to bill EIB services (all boxes that are checked use exact service date) and lastly any EI Evaluations, clearly dated in that column.
*Waypoint (formerly CFS) be sure to look at Coordination column and bill for any with a date (using month end date!) also be sure to bill the EIB Services under Activity code MP and use the actual service date, and lastly bill for EI evals in the coordination column it will say EVAL, use the exact date provided to bill charge.
*They never submit NCCW billing FYI
*EIB is a bundle service it includes Therapy FYI
*Each Spring Management will tell you to stop all billing. They are allotted Funds differently. Prior to Fiscal year end it will be calculated how much more if any you may bill and CFO will state exactly what to bill. Do not start again until notified
*SC is billed 1 per month. Eval possibly twice per year, EIB 1 per week. NH Leads prevents claim from generating if 2 EIB occurred in 1 week span.
*RMCC is E24000 and Child and Family is E20000
*They provide services whether they have Medicaid or not. If they don’t have Medicaid they fund raise throughout the year to get money.
*They should not be submitting attendance if they do not have Medicaid, they do not always know and it is up to RMCC or Waypoint to contact the family and try to fix the issue. As of 2019 also notify Stephanie Auclair, Lenore S.
*EI services are only up to 3 years old
How to enter IHS (In House Support)

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date-always enter full month range
2. Search for the Consumer
3. Select correct Service code for IHS (There are 5 Listed on BDS sheet)
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
7. You must enter the $dollar amount provided for each charge on Attn. sheet. Type this in Rate Box
8. You will always select the last date of the month to bill
9. SAVE (upper left)

Notes on IHS

*Currently Brandie submits the attendance once a month. She will provide the $$amount to bill for each charge. There can be up to 4 codes on her typical attendance to bill for one client. The 5th code (IHS EMOD) will be submitted on EMOD attendance and billed through the EMOD screen)
*The codes are: IHS PDM PC, (personal care) IHS PDM Consult (consultations), IHS PDM FSSC (Service coordination and the ONLY SC not billed through the CM screen) and IHS PDM Respite (Respite IHS this is not submitted with the typical Respite billing)
*The Rates can and usually do change from Month to Month
*The Real attendance sheets comes from the family, Brandie is the one that provides us with billing details.
*Currently you can’t bill SSLHRST for IHS Client although Karen McLaughlin is looking into this
How to Enter CDS/PDMS Attendance

1. Start Date and End Date-always enter full month range
2. Search for the Consumer
3. Select correct Service code for CDS Code (There are 6 listed on BDS sheet)
4. Select Correct Service Provider
5. If all information looks correct click Generate Calendar.
6. AS LONG AS THERE IS A PA ENTERED, the correct $$ Amount will default in rate box
7. You will always select the last billable date of the month to bill
8. SAVE (upper left)

Notes on CDS/PDMS

*There are currently 6 codes listed on BDS sheet.
*I03=CDS Plan 525 also known as PDMS
*CDS-Consumer Directed Services
*Billing comes from the family. Currently Brandie is submitting the attendance
*Attendance should only be submitted once per month. (there are clients that get submitted bi-monthly-these are set aside and tracked-do not enter until end of month)
*All CDS programs have the First 3 Letters as Program, the Last 3 letters are: 1st Initial of first name and Last 2 are the First 2 letters of the last name. Example: John Smith would be I03JSM.
*Many times Management will change the dollar amount billed. It is all based off of the PA. (I have seen some months zero billed the next month higher than normal etc)
*Many times due to the changing of dollar billed during the 12 months, a claim (Usually the 12th one) may hang up on the pending report for insufficient dollars. (Person working pending would need to research be sure all dollars BILLED not necessarily received-take into account Cost of Cares!) And then the rate would be corrected in the rate box.
*Per Brandie on 100518 if attendance sheet is blank but a contact was made by Service Cord. It is billable. Date of contact should be on sheet
How to Enter Home Modification /EMOD Billing

NH Leads
Service Capture
Environmental Modification

1. Enter Date provided on attendance
2. Select Consumer
3. Make certain a GL code populates on screen to right
4. In EMOD log click NEW
5. A box will populate showing the actual PA, $ and code
6. IF YOU ARE BILLING 1 UNIT EXACTLY FOR THE PA $$ THEN CLICK ON HIGHLIGHTED PA
7. CLICK SAVE
8. IF YOU ARE NOT BILLING FULL PA $$!! For example some EMOD’s are 2 units at different $$ amounts, then you would follow above except at step 6, you will still click on the highlighted PA then you would actually need to type in the dollar amount to be billed for that date of service. Click Save.

Notes regarding EMOD

* Brandie Via Bill currently submits Attendance for EMOD’s
* You can never enter an EMOD unless there is a PA entered
* Attendance should tell you the date of service. If they did not, you can pick a logical date on the attendance sheet AS LONG AS IT IS WITHIN THE PA DATES.
* Most Emod PA’s are only for a short date range.
* again, note above, a client could have 3 different charges for an EMOD against the same PA, so again when entering attendance you would have to type over dollar amount

How to Enter Specialty Services/SSL /SIS and HRST Attendance

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date-always enter full month range
2. Search for the Consumer
3. Select correct Service code SSLHRST_2013 OR SSL1_2013
4. Select Correct Service Provider S01 OR WATCH S06* READ NOTES BELOW
5. If all information looks correct click Generate Calendar.
6. For HRST BILLING simply click the date of service then click save (upper left)
9. For specialty services billing be-careful, put correct units in each date of service then click save
10. Watch for SIS billing but done the same way enter units on date of service and click save
Notes regarding HRST, SIS and Specialty Services

*Bill sends clinical billing SPECIALTY SERVICES each month uploads to Ebridge.
*The attendance for clinical comes from Vendors and One Sky Clinicians, sometimes you add them together they could be on same date of service, 90% are in house.
*Clinical Billing must be converted to units. There are 2 units per hour. 1 unit is 30 minutes. T2025 codes. If they provide .75 hours that is one unit. We are not rounding up. Another example .50 hours is 30 minutes is 1 unit. .25 is ¼ hour or 15 minutes I am not rounding up for extra .25 unless it combines with a second sheet with exact date of service and it creates 1 unit together.
*Was told to watch units no more than 6 hours per day or 12 units per day
*Ways to calculate: take $ amount divide by $45.90 units round up or down (I am not doing this Code is based on time, 30 minutes, not dollars.) OR hours x2=units
*Always select the SSL1_2013 code GL is S06 for SSL Vendor and clinical SSL
*NH Leads will not let you bill more than 12 units per day, it is a loss if over provided will not carry to antoher date unless Someone clarifies
*Emailed BDS and Called Reba asked for clarification in October 2018 no response. Told Fran on 102518 I will not combine units for different DOS or roll up extra .25 with different DOS etc until provided info

*Re SIS billing: Bill sends these each month, they are like HRST evaluations BUT only 1 per 5 years.
*Typically, 7 units on date of service, but Bill will tell you
*Problem is that they are the EXACT same procedure code as clinical billing SSL1_2013 BUT different GL code (S01) and they pay at a higher rate. Sometimes clients will have both, clinical billing and a SIS, watch the GL code, sometimes they must be changed in order to bill the SIS etc.

*For SSLASSESS_2013- Bill also sends these. Rare, but he will tell you the $value to enter as well as the date of service

*HRST billing comes from Brandie Accounting Manager. Once per month (client can have HRST once per year)
*HRST is in Zunk in BTS not entered into individual names
* You can bill HRST with CDS
*HRST with I HS i is an issue. We are not currently billing it, nor is it added to PA. SC Manager was looking into it as she believes it should be a covered service
Per Bill they would never just request a PA for only a HRST
HRST typically 1 per Year and SIS once every 5 years, per Bill you can bill both 2/27/19
*Per Lenore on 012819 client can’t have NCCW/FSNCCW and then bill for a DD code HRST
How to Enter Respite Attendance

NH Leads
Service Capture
Service Capture again
General Attendance

1. Start Date and End Date-always enter full month range
2. Search for the Consumer
3. Select correct Service code RESP OR NRESP
4. Select Correct Service Provider F01 IS GI CODE
5. If all information looks correct click Generate Calendar.
7. Enter units on each date of service click save upper left

Notes Regarding Respite

*CCW=RESP=Billable=Medicaid
*NCCW=NRESP=zero$-Non billable-Non Medicaid=State dollars
*$money comes from Zunk
*People switch in an out
*Brandie sends Respite billing each month. Spreadsheet as of 09/18
*You can’t bill RESP when someone has a targeted CM True
*You can’t bill RESP when someone has Residential
*You can’t bill RESP when someone has CDS
*You have to convert the hours to units. There are 4 units per hour. So 4 hours is 16 units
*Per Conduent you can only bill up to 96 units per day (24 hours x4 =96 logic)
*Per Lenore on 012819 can’t bill NCCW/FSNCCW for someone who has RESP one says Non DD elig Medicaid one says DD elig.
After all Attendance is entered in NH LEADS

Step 1: Validate Claims
Service Capture
Claims
Validation-(Go back 1 year from the day you are validating on. For Example if today is 092517
pick dates ------092516-091517)
WAIT!
A Screen will pop up with dates and amounts. Copy this screen, send it to Rocco, Minda
Create Bills (upper left box)
Period to Post Pops up-(Be careful of Month end)
OK
Bills created successfully! (Any problems, contact CSNI)

Step 2: Prepare 837
Claims
Transmission
New (It will show you the claims you just created)
Prepare 837 (Top Left)
OK
WAIT! (At least 5-10 minutes depending on file size)

Step 3: Download 837
Claims
Transmission
Download 837
Highlight the file (take note of batch # starts with a 2)
Download file (upper left)
Save As 837_MM,DD,YY_Batch#
(Save to Folder ECRS 837)
NH Leads is done

Continued 837 Instructions

Step 4 Upload to MMIS
Log onto MMIS (DD provider number only)
EDI
Upload X12
Browse-(Find your file you just saved to your folder)
Click on it-and Click Submit
Log off

Step 5 Check for Errors
Wait about ½ hour or so
Log back on
EDI
File Retrieval Mailbox
Proprietary
Error Rpt
Put in today’s date for both
Check Show All
Search
The file will come up as 2 reports (Audit and Report)
Click Report – (On the first page you should see claims count and rejected zero. 3rd page has
Accepted $ charge and claims count, batch number. Make sure this $ matches what you
validated)
Also, the next day log back on and click 999 Look for IK5 Accept- Reject- Error. If you need further details
AK1 is good

1. Always As stated above look for errors on that Report at MMIS. It will tell you how many errors there were and what this issue is. Most common are incomplete address or zip codes. You will have to search the actual 837 with the claim line to find the client. Notify CSNI for help if you cannot figure out who the client is. It can be difficult without knowledge of 837.
Once you determine the client, you will have to have to correct the errors. Then contact CSNI to rebatch the claims or create an 837 for you. You cannot do it yourself. (If you do not look for the errors these claims will never be processed. As far as MMIS is concerned they never uploaded and they will be stuck in Batch mode.)

2. To Check for errors that occurred at time of creating 837 Go to Service Capture,
Administration
Download 837 Error Log. Click most recent view it. It will give you claim number. You will have to research to try to figure out why it had an error. Most times CSNI will be involved. It could be many things. PA issues etc. If you find the error and correct it, the next time you validate claims it will go through. Also, this report is cumulative, thus if you do not fix the error it will stay on each week until it does get corrected.

3. Errors while creating files. You will need to contact CSNI. Most common error is “Bill charge Insert” This means that CSNI was not notified by the PA department of a NEW DH6 rate or Sep3 rate. Calculate rate and provide to them. The next most common error is that you have too many claims.
Notes of Interest regarding 837

WATCH END OF MONTH! - You May have 2 months open, be sure to pick correct month end or never choose a month prior for a current month’s billing! You may have to validate twice.

VALIDATE OFTEN. Especially if you entered a lot of attendance. You may get hung up or lose attendance
You can submit 15 months but. ANYTHING older than 15 months must be done by CSNI.

Always send $$ validated to Rocco and Minda

Must always have .837 when naming file

Per Cris if you validate you can adjust claims still. Another words, go fix it in attendance. If you “create bills” that is the point of no return.
Per Cris, if you want to validate, run validation report in Reports/service capture/billing claims by status and view for errors etc, BUT if you do this and you did leave the validation screen you must REVALIDATE
Also Per Cris, if you had validated unbillables you do NOT want to revalidate unbillables. VERY CONFUSING.

UNBILLABLES!!!--You should validate unbillables at least once per month and if you have skipped a month it is best to do 3 or 4 months at a time, (not a year) it will take longer to validate. Or if PA dept. notifies you of a PA change. Once attendance is marked an unbillable charge it will not be released unless more units are added to a PA. (Thus if you get into the habit of this once per month if PA dept. forgets to notify billing it will be caught this way).

You have to “create Bills” after each validation. You don’t however have to create the 837 each time.
So Validate, create bills, validate create bills, as many times as you want. Then go make the 837 only once, it will pull together a grand total of all times you validated.
835 Instructions

**Last Date Updated: September 25, 2017**

Any Problems with 835 contact Christine Philipson at CSNI she works on NH Leads problems cphilipson@csni.org Phone # 603-319-4785

Currently 835 is downloaded on Friday mornings.

**Step 1: Download Eob’s and the Native Dat File**

Before you start log into MMIS under each of the 5 provider numbers. Download each EOB. Save the EOB using this format: **Example: DD.MM.DD.YYYY_RA#** (or IHS, ABD, EI, NCCW)  
Save the EOB to: Department Y-Business office-ECRS-NH Medicaid EOB’s and Select correct Service type folder.  
Print a copy of the page with Total amount paid for each EOB, it will help you later.

Log into MMIS using the DD provider number (This is the only one to download for all 5 provider #’s)  
Go to EDI  
X12 File Retrieval Mailbox  
Select 835 from the Drop Down  
Put Thursday and Fridays date for Viewing range of of 835’s  
Check Show All  
Double click Native Dat  
Report opens very messy. Very carefully in first row find the + sign. You must change this to a Colon:  
File Save as (be sure All Types is set –no text document)  
Name it in this format: 835_MM.DD.YY_Batch#.835 (The batch number is part of the native file it should be the last 6 digits) (MAKE SURE YOU PUT THE .835!)  
Save it to: Department Y-Business Office-ECRS-835 folder  
Log out
Continued-835 Instructions-

**Step 2: Upload the 835 file from Folder to Remittance/documents file in Leads**

Sign into NH Leads
Service Capture
Remittance
Documents
Upload 835 (right side Import)
Browse for file click it
Upload (left side button)

**Step 3: Import the 835-Match totals and enter correct Data of EOB**

In the same place service capture….
Remittance
Documents
Import
Highlight File (click to highlight)
Import (on upper right side)
When Box comes up you can see the claims being imported after 5 minutes you can close it BUT

**WAIT ½ HOUR BEFORE DOING THE NEXT STEP! The reason for this is a problem with NH Leads. Not all denials will post if you upload and post too quickly. (Ask Cris or is it at next step clarify)**

**Step 4: Enter Check Information and Posting the cash**
This populates a list
Click on one of the files (you may have 1-5 files and yes always do the zero ones, so denials post)
It should pop up Now enter
RA#
Put Check date. Keep same date on the EOB
PROVIDER NUMBER!!! SELECT CORRECT ONE YOU ARE POSTING
For Check # just put DD or ABD or HIS or NCCW or EI
Make sure the totals match the EOB (Look at the EOB total page you previously printed!)
Save
Ok
(Suggestion from Cris is to complete the process by posting this payment now-do not do it later…causes Issues)
Continued-835-Instructions

After you have completed step above now
Double click the same file (it will come up again)
Also Make sure the $ amount Internal matches the Matched….upper right box
Slide the ruler bar over at bottom of box that pops up towards the right
You should now see Apply Remittance (on top)
Click this.
Your totals should still equal (Internal and the Matched should have moved to Applied)
(If you do not match, contact Cris P.)
When done with this hit Cancel, it brings you back to get ready to start the next EOB payment.

Notes of Interest:

1. I was negative in variance. I had an old Date of service pay, it could not post. CSNI put it
   to Batch mode as it was “not rebilled by us” Once that was done (claim# put as Batched”)
   go back to Remit. Click New. Enter Claim #. Process as primary and save. Go back
   and apply the remit. Also it said External and also had to do this.

2. Another example: I had old claims submitted to Conduent on spreadsheet. If they are not
   too old and we can validate (not older than 15 months) then, Rebill the claim. Validate
   the dates for these claims only. Create Bills. DO NOT create and 837. Go back and post
   cash.

3. If Conduent/Medicaid recoups More $ than what was paid on an EOB, you must get Cris
   at CSNI to fix it. You will need to track this as it could take more than several remits to
   fully recoup.

4. All Adjustments requested through Conduent will not post automatically as the claims are
   typically in denied status. Contact CSNI provide Batch# and deposit date. Provide Claim
   numbers on a spreadsheet and request them to apply.

5. Per Cris on 12/06/17 some things listed here that make you NOT balance A) could be
   cost of care overpayments, when they take a cost of care in error and repay you it comes
   in one lump sum. B) If you refund a claim that had a partial cost of are taken and you
   reversed it, it may somehow thro you off balance. C.) she said on 052119 to handle these
   overpayments write them off.

6. Always run reports after you post cash. You should know the dates that should be
   processed, thus: A) run a batched report Nothing should be in batch mode anymore
except newly (within the most recent billing not set to be paid on this 837. If there is claims batched, research, that’s a problem B) Run Rebilled, same as above nothing should be in Rebill mode C) Run Void Requested same as above and D) run Overpaid. E) Denied F) Pending - You can do these in reports or claims file. See Report section

7. I sent Adj. Req. They RC and Repaid same claim. I had to:

A) put all recouped claims as void req.
B) I reposted
C) I had to create new claims, validate and create claims (no 837)
D.) In cash I had to add the new claim # to the 835 and post, (reconfirm this last part)
E.) There may be a problem as there is an original $ amount and now a new created amount, Cris most likely has to get involved to removed the extra dollars.
General Information about One Sky

1. Someone wants services
2. Goes through family support or adult service coordinator. These people determine if they are eligible to get services
3. Must Be Medicaid eligible and AA area agency eligible
4. SIS-Supports intensity scale. Need auth to be done and HRST Health risk screening 2 evals need to be done. Needs auth. They have to be done before they come off of the wait list
5. Wait List-Rocco on committee, SC, family support functional screen from budget, elig etc., can wait a few years
6. Once approved, comes off wait list. Packet from SC needs to be completed. Bill and billing sign it off. Changes comes in packet also. Chris M must sign off on crisis change. There is more to this not written
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<tr>
<th>Acronym</th>
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<td>ABD</td>
<td>ACQUIRED BRAIN DISORDER</td>
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<td>BDS</td>
<td>BUREAU OF DEVELOPMENTAL SERVICES</td>
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<td>BTS</td>
<td>BUDGET TRACKING SYSTEM</td>
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<td>CONSUMER DIRECTED SERVICES</td>
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