

PSH Electronic Application Process

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Summary:

This document will step through the process of submitting an electronic application for Permanent Supportive Housing through the use of ProviderConnect.

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Updated on 09/07/2011

Glossary of Terms

- ▶ PSH – Permanent Supportive Housing



Preparing to Submit a PSH Electronic Application

- ▶ Before submitting a PSH electronic application
 - Consumers must be registered with the Collaborative.
 - You must first have a PSH Intake completed, approved and on file with the Collaborative. An Intake can only be requested during the open period that is specified within the Provider Communication Alert prior to the round. There are no exceptions before or after this period.
 - Only DMH Certified Providers may request a PSH Intake.
 - To request a PSH Intake, call the Illinois Mental Health Collaborative at 866-359-7953 (Mon-Fri 8am-5pm CST). The intake will be completed, by a Collaborative clinician, and put on file during the call.

Information Needed For Requesting PSH Intake

- ▶ Agency Information
 - FEIN
 - Address
 - Phone Number
 - Region



Information Needed For Requesting PSH Intake (continued)

▶ Consumer Information

- RIN
- Current Placement
 - Homeless
 - Aging out ICG recipient
 - Aging out DCFS ward
 - Resident of long term care
 - At risk of placement in long term care
 - Extended long term patient of a state hospital
 - Resident of DMH funded, supported, or supervised residential setting

Information Needed for Requesting PSH Intake (continued)

- ▶ Consumer Information (continued)
 - Name of Applicant
 - Date of Birth
 - Address
 - County
 - Home Phone
 - Work Phone
 - Medicaid Funding Verification



Getting Started

The screenshot shows a web browser window with the address <http://www.illinoismentalhealthcollaborative.com/providers.htm>. The page header includes the logo for the Illinois Mental Health Collaborative, the tagline "FOR ACCESS AND CHOICE", and navigation tabs for "About", "Services", "Feedback", and "Contact".

The main content area is titled "Provider Online Services" and features a "Welcome to" message. A blue box with the text "Log in to ProviderConnect" is overlaid on the page, with a red arrow pointing down to the "LOG IN" button. The "LOG IN" button is highlighted with a blue square icon. Other buttons visible are "REGISTER" (with a green square icon) and "DEMO" (with a blue square icon).

Below the buttons, there is a paragraph of text: "Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request outpatient authorizations and more. ProviderConnect is easy to use, secure and available 24/7."

At the bottom of the main content area, there is another paragraph: "Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources."

On the left side of the page, there is a sidebar with a navigation menu:

- Home
- Provider Home**
- Provider Manual
- Provider Forms
- ReferralConnect

There is also a photo of a woman and the text "for providers" and "Provider Online Services" in the sidebar area.

Home Page

Home

- Specific Member Search
- Register Member
- Authorization Listing
- Enter an Authorization Request
- View Clinical Request Drafts
- Claim Listing and Submission
- Enter a Special Program Application**
- EDI Homepage
- On Track Outcomes
- Reports
- My Online Profile
- My Practice Information
- Provider Data Sheet
- Compliance
- Handbooks
- Forms
- Network Specific Information
- Education Center

Welcome Provider

Thank you for using ValueOptions

WHAT DO YOU WANT TO DO TODAY?

- ▶ [Specific Member Search \(eligibility, benefits, claims, authorizations\)](#)
- ▶ [Register Member](#)
- ▶ [Review Claims](#)
- ▶ [Enter a Claim](#)
- ▶ [Review an Authorization](#)
- ▶ [Enter an Authorization Request](#)
- ▶ [View Clinical Request Drafts](#)
- ▶ [View My Recent Provider Summary Vouchers](#)
- ▶ **[Enter a Special Program Application](#)**

YOUR MESSAGE CENTER

INBOX

SENT

Your Recent Inquiries box is empty

CLINICAL SUPPORT TOOLS

- ▶ [View My Outcomes with On Track](#)

NEWS & ALERTS

Disclaimer Page

Disclaimer

Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests for a special program application. Exiting or aborting the process prior to completion will not result in a completed request. ValueOptions does not recognize or retain data for partially completed requests. Upon full completion of the "Enter a Special Program Application" process, you will receive a screen noting the pending or approved status of your request. Receipt of this screen is notification that your request has been received by ValueOptions.

Next

After reading the disclaimer, click "Next".

Search a Member

Eligibility & Benefits Search

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID	<input type="text"/>	(No spaces or dashes)
Last Name	<input type="text"/>	
First Name	<input type="text"/>	
*Date of Birth	<input type="text"/>	(MMDDYYYY)
As of Date	<input type="text" value="11172009"/>	(MMDDYYYY)
	<input type="button" value="Search"/>	

Enter as much information as possible to narrow the search. However, Member ID and Date of Birth are required fields.
(Note: Member ID is equivalent to the Consumer's RIN)

Demographics Verification

Home
Specific Consumer Search
Register Consumer
Authorization Listing
Enter an Authorization Request
View Clinical Request Drafts
Claim Listing and Submission
Enter a Special Program Application

EDI Homepage

On Track Outcomes

Reports

My Online Profile
My Practice Information
Provider Data Sheet

Compliance

Handbooks

Forms

Network Specific Information

Education Center

ValueSelect Designation

Contact Us

Demographics Enrollment History COB Benefits Additional Information

Consumer eligibility does not guarantee payment. All information is provided by our clients.

Consumer [?]

Consumer ID **748159263**

Alternate ID

Consumer Name **JONES, GARY**

Date of Birth **01/01/1985**

Address **1 FAKE ST
CHICAGO, IL
60606**

Alternate Address

Marital Status -

Home Phone

Work Phone

Relationship **1**

Gender **M - Male**

Eligibility

Effective Date **07/01/2008**

Expiration Date

COB Effective Date [?]

[View Funding Source Enrollment Details](#)

Subscriber

Subscriber ID **748159263**

Subscriber Name **JONES, GARY**

Next

Consumer ID is equivalent to the Consumer's RIN

After confirming the correct consumer has been located, click "Next".

Application Landing Page

Special Program Application

All fields marked with an asterisk () are required.
Note: Disable pop-up blocker functionality to view all appropriate links.*

***Application Type**
Please only select the Special Program Application Type for which your agency is authorized.

SELECT...
PERMANENT SUPPORTIVE HOUSING
MONEY FOLLOWS THE PERSON
RAPID RE-INTEGRATION

Tax ID: _____ Provider ID: **299084**

Consumer ID: **748159263** Last Name: **JONES**

Attach a Document

*Complete the form below to attach a document with this Request
The following fields are only required if you are uploading a document*

*Document Type: _____

Does this Document contain clinical information about the Consumer? Yes No

*Document Description: SELECT...
UploadFile Click to attach a document Delete Click to delete an attached document

Attached Document:

Back Next

Select the type of application you want to submit.

This section allows you to attach or "upload" multiple supporting documents to the application. If you would rather fax all supporting documents, skip this section.

If the "Document Type" is clinical then the document will be encrypted.

Select a document description then click "Upload File".

Attaching Documents (continued)

Special Program Application

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality.

***Application Type**
Please only select the Special Program Application type.
PERMANENT SUPPORTIVE HOUSING

Upload File - Microsoft Internet Explorer
Click the browse Button to find the file you want to Attach
Click Upload when done.

File: Browse...
Upload

After clicking "Upload File", on the previous screen, the Upload File window will appear. Follow the directions accordingly.

Consumer

Consumer ID	Last Name	First Name	Date of Birth (MMDDYYYY)
748159263	JONES	GARY	01011985

Attach a Document

Complete the form below to attach a document with this Request
The following fields are only required if you are uploading a document

*Document Type: Does this Document contain clinical information about the Consumer? Yes No

*Document Description:

UploadFile Click to attach a document Delete Click to delete an attached document

Application Landing Page (after uploading a document)

Special Program Application

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

***Application Type**
Please only select the Special Program Application Type for which your agency is authorized.
PERMANENT SUPPORTIVE HOUSING

Provider

Tax ID	Provider ID	Provider Last Name	Vendor ID
	299084	JANET WATTLES MENTAL	IL1000000

Last Name
JONES

Attach a Document

Complete the form below to attach a document with this Request
The following fields are only required if you are uploading a document

*Document Type: Does this Document contain clinical information about the Consumer? Yes No

*Document Description: SELECT...

UploadFile Click to attach a document Delete Click to delete an attached document

Attached Document:
 (Clinical Test Document.doc) - Secure-Clinical Document - PCRF501

Back Next

As each document is uploaded it will appear in this area.

Notice the "Document Type" and "Document Description" fields have cleared. This allows you to repeat the uploading process as many times as necessary.

When finished uploading, click "Next"

Special Program Application

Section 2

Section 2: Eligibility for Bridge Subsidy Initiative

*1. Has a mental health assessment been completed by a Division of Mental Health contracted community health center within the last 12 months? Yes No

If yes, name of mental health center

Care Manager/Therapist Name

Care Manager/Therapist Address

City State Zip

Phone number of care manager/therapist

Care Manager/Therapist Email Address

Mailing address if different than above Mailing Zip

1a. For MFP Applicants: Applicant has been in a nursing home (non-IMD) on a continuous/concurrent basis for six (6) months or longer Yes No

1b. For RRP Applicants: Applicant has been in a nursing home (non-IMD) for 12 months or less Yes No

*2. Does consumer have an Axis 1 diagnosis of serious mental illness or co-occurring mental illness and substance abuse diagnosis?
Information must be completed for all five axes: Yes No

Some questions are required depending on the answer to a previous question. For instance, if the answer to #1 is 'Yes' then you must enter the name of the mental health center.

Special Program Application Section 2 (continued)

Diagnosis
Please indicate primary diagnosis

Axis I

* Diagnosis Code 1 Description

Diagnosis Code 2 Description

Diagnosis Code 3 Description

Axis II

* Diagnosis Code 1 Description

Diagnosis Code 2 Description

Diagnosis Code 3 Description

Axis III

* Diagnosis Code 1

Diagnosis Code 2

Diagnosis Code 3

***Axis IV**

Check all that apply

- None
- Financial problems
- Housing Problems
- Occupational problems
- Problems with Primary support group
- Unknown
- Educational problems
- Problems with access to health care services
- Problems related to interaction w/legal system/crime
- Other psychosocial and environmental problems
- Problems related to the social environment

Axis V

* Current GAF Score

* Highest GAF Score in the Past Year

At least one entry is required for Axes I - IV.

Axis V consists of two fields that are both required.

Special Program Application Section 2 (continued)

For any Axis III diagnosis or condition listed, please describe how consumer is being assisted to manage this condition:

***Does consumer have a dual diagnosis mental illness and developmental disability (MI-DD)?** Yes No

If yes, please identify the DD Diagnosis

LOCUS Results

Functional Impairment Domain Scores:

*Risk of Harm	<input type="text" value="SELECT..."/>	*Recovery - Environment Stressors	<input type="text" value="SELECT..."/>
*Functional Status	<input type="text" value="SELECT..."/>	*Recovery - Environment Supports	<input type="text" value="SELECT..."/>
*Co-Morbidity	<input type="text" value="SELECT..."/>	*Recovery and Treatment History	<input type="text" value="SELECT..."/>
		*Acceptance and Engagement	<input type="text" value="SELECT..."/>

Composite Score

Level of Care Recommended - Locus

Level of Care Recommended - Assessors

Reason for deviation of recommended Level of Care

These fields are required.

This field is only required if the answer to the previous question is 'Yes'.

Special Program Application

Section 2 (continued)

3. Please indicate which of the following categories best apply to the consumer. At least one must be checked for the application to be considered eligible for the DMH Bridge Subsidy Initiative.

Resident of a Long Term Care Facility (nursing facility)

Name of Facility

Location of Facility (City/State)

At risk of placement in a Long Term Care Facility.
To qualify for this priority population category, you must also answer "yes" to the following question:
Has the applicant had a recent (within 60 days) Pre-Admission Screening/Mental Health and been either determined to be appropriate for Long Term Care admission on a time limited basis or determined to be appropriate for community resources/residential alternatives? Yes No

Extended long-term (more than 6 months) patient

Name of Hospital

Location of Hospital (City/State)

Aging out adolescent or young adult in the Individual Care Grant (ICG) program

ICG Location (City/State)

If you are in an ICG program, in how many months will you age out?

An aging out ward of Department of Child and Family Services guardianship

DCFS Location (City/State)

If you are in an DCFS program, in how many months will you age out?

Resident of a DMH contracted supervised or supported (including MH-CILA) residential treatment setting

Name of Provider Operating the Program:

DMH Location (City/State)

Currently experiencing chronic homelessness as defined by DMH. To qualify for this priority population category, consumer must also answer "yes" to the following two questions:

1. Has consumer been continuously homeless for a year or more OR have had a least four (4) distinct episodes of homelessness in the past three (3) years? Yes No

2. Is consumer currently residing in a place not meant for human habitation (e.g., living on the street), a safe haven, or in an emergency shelter? (In rural communities that utilize hotel/motel vouchers in lieu of emergency shelter, individuals making use of such vouchers may check "yes" to this item only if the hotel/motel stay is time limited and funded by a third party.) Yes No

At least one check box must be marked.

Special Program Application

Section 2 (continued)

4. In order to qualify for the DMH PSH Bridge Subsidy initiative, the consumer must have a current household income at or below 30% of Area Median Income(AMI). Household income includes any regular income or benefits received by all adult member(s) of the consumer`s household. If the consumer does not know the AMI for his/her area, please visit the following link: <http://www.huduser.org/Datasets/IL/IL03/il.pdf>

*4a. Is the consumer`s income level currently at or below 30% of the Area Median Income (AMI)?

Yes No

These fields are required.

*4b. Please estimate the total combined monthly income for everyone who will live in the household. Please fill out the application appendix document containing the Household Income chart and attach it to the application via the secure clinical attachment function or fax it.

*5. If you are accepted into the DMH PSH Bridge Subsidy Initiative you must be currently on a waiting list for a Section 8 Housing Choice Voucher (HCV) or comparable rental subsidy OR agree to register/apply for a HCV or comparable permanent rental subsidy when such opportunities are available. Does consumer agree to maintain his/her status on such a waitlist or apply for open lists when possible?

Yes No

*6. In addition to maintaining consumer`s status on or applying for an HCV or other rental subsidy list, the consumer must agree to accept an HCV voucher or other comparable tenant-based rental subsidy if it is offered to the consumer. Does the consumer agree to accept a tenant-based HCV voucher or other comparable rental subsidy if it is offered to the consumer?

Yes No

Special Program Application

Section 3

This question is required.

If there are no additional household members to list, please check "None".

Section 3: Household Information

7. List all other persons (immediate family, only) who will be living in the unit and their relationship to the applicant. Complete the information in the chart for all members of the household.

First Name	Last Name	Relationship to Applicant	Birth Date (MMDDYYYY)	Age	Sex	Social Security # (No dashes)	No SSN	Unknown
<input type="text"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/> <input type="button" value="📅"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/> <input type="button" value="📅"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/> <input type="button" value="📅"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/> <input type="button" value="📅"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/> <input type="button" value="📅"/>	<input type="text"/>	SELECT... <input type="button" value="v"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

When entering data for a household member, every field for that member is required.

If there is not a Social Security Number to enter, please choose "No SSN" or "Unknown" whichever is applicable.

Special Program Application

Section 3

8. Criminal History: An answer of "yes" to any of the following questions will not necessarily result in a denial of your application for the Bridge Subsidy initiative. This information is being requested to evaluate if adequate supports could be provided in order to ensure the consumer's success in permanent supported housing.

*Does consumer or any member of consumer's household who will live in the unit have a criminal record? Yes No

If "Yes" to the above please indicate whether any of the following statements apply to the consumer or any member of the consumer's household.

8a. Charged or convicted of fire setting/arson within the past 3 years. Yes No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant Household Member (please specify) _____

8b. Charged or convicted of child sexual abuse within the past 3 years.

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant Household Member (please specify) _____

8c. Charged or convicted of sexual violence or assault within the past 3 years. Yes No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant Household Member (please specify) _____

8d. Charged or convicted of violent crime within the past 3 years.

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant Household Member (please specify) _____

8e. On the Sexual Violent Crime Registry. Yes No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant Household Member (please specify) _____

8f. Other criminal charges or convictions in the last 3 years not specified in 8a-e. Yes No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant Household Member (please specify) _____

Explanation of any "yes" statements checked above

This response is required.

Questions 8a - 8f are only required if the answer to question 8 is 'Yes'.

Special Program Application Section 3 (continued)

If you choose to fax the supporting documents, they must be faxed within one business day of submitting the application. **If not, the application will be voided.**

Application Checklist (Please indicate if document is attached as a secure clinical attachment or is being faxed)

All required supporting documents for this application, including the Mental Health Assessment, LOCUS Assessment, and Individual Treatment Plan, must either be attached as "secure clinical" documents to this application or faxed to the Collaborative (at 866-928-7177) within one business day of this application completion. Should the required documents not be faxed to the Collaborative within one business day, the application will not be considered for processing. The provider will be required to request a new intake for application and to submit a new application.

Attached Faxed

<input type="radio"/>	<input type="radio"/>	*A copy of the Mental Health Assessment within one year from its origination date. A one page addendum is required if there have been significant clinical changes during this time frame. The document should be titled <u>Mental Health Assessment Addendum</u> .
<input type="radio"/>	<input type="radio"/>	*A copy of the LOCUS assessment completed within the last sixty (60) days. A LOCUS dated later than sixty days will not be accepted.
<input type="radio"/>	<input type="radio"/>	*A copy of the Treatment Plan completed within six (6) months of the application.
<input type="radio"/>	<input type="radio"/>	*If "at risk of nursing home placement" is selected as the priority population for this application, A Copy of the Determination Letter for the Pre-Admission Screening/Mental Health (PAS/MH) must be submitted. The PAS/MH must have been completed within 60 days of the application.
<input type="radio"/>	<input type="radio"/>	*Completed application appendix document: Household Income Chart
<input type="radio"/>	<input type="radio"/>	*Documentation of income such as a pay stub or social security letter

It is required that you mark how each supporting document will be submitted.

Special Program Application

Section 4

Signature page, with applicant signature, must be faxed within one business day of submitting the application. **If not, the application will be voided.**

Section 4: Signatures

Signature page with applicant signature must be faxed to the Collaborative within one business day of this application completion, at 866-928-7177. Should the signature page not be faxed to the Collaborative within one business day, the application will not be considered for processing. The provider will be required to request a new intake for application and to submit a new application.

Please confirm your acknowledgement of these conditions.

I understand and affirm that if the applicant is approved for a Bridge Subsidy and is currently residing in a DMH contracted supervised or supported residential treatment setting (including MH-CILA) he or she will move out of this setting to execute the Bridge Subsidy:

*Enter Applicant`s Name	Signature	*Date (MMDDYYYY)
<input type="text"/>	<input type="text" value="Enter on printed form"/>	<input type="text"/>
*Enter Care Manager`s Name	Signature	*Date (MMDDYYYY)
<input type="text"/>	<input type="text" value="Enter on printed form"/>	<input type="text"/>

I authorize the Division of Mental Health and its Supportive Housing Bridge Subsidy Administration to determine my eligibility for Access and Choice and/or the Permanent Subsidy Initiative and to contact my care manager for additional information. I agree to complete additional forms/documentation that may be required to process my application. I agree that the information contained in this form is true to the best of my knowledge.

*Enter Applicant`s Name	Signature	*Date (MMDDYYYY)
<input type="text"/>	<input type="text" value="Enter on printed form"/>	<input type="text"/>

I certify that I have reviewed all information contained in this referral with the Applicant and that all information is true to the best of my knowledge.

*Enter Care Manager`s Name	Signature	*Date (MMDDYYYY)
<input type="text"/>	<input type="text" value="Enter on printed form"/>	<input type="text"/>

Thank you for completing the Division of Mental Health Permanent Supportive Housing Bridge Subsidy Initiative. The information you have provided will be reviewed and a response will be provided to you.

All four name and date fields are required.

Once "Submit" is clicked, you can no longer attach any documentation. If you need to attach additional documents click "Back" to do so.

Special Program Application

Submission of Incomplete Information

- Applicant Phone # should only contain numbers.
- Hispanic Origin is required.

Application

Intake Request Date
(applicable for PSH application only) (MMDDYYYY)

11172009

Section 1: Applicant (Head of Household) Information

Phone #

Jon Doe

Work #

Ext

Email

Fax #

*Race

- | | |
|---|--|
| <input checked="" type="checkbox"/> White | <input checked="" type="checkbox"/> Black or African American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> American Indian or Alaskan Native | <input checked="" type="checkbox"/> Asian and White |
| <input type="checkbox"/> American Indian/Alaskan Native and White | <input type="checkbox"/> American Indian/Alaskan Native and Black |
| <input type="checkbox"/> Black/African American and White | <input type="checkbox"/> Other |

Consumer's Ethnicity (Please select "yes" or "no" for Hispanic Origin. Consumer should select both a "Race" category and a "yes" or "no" for Hispanic Origin):

*Hispanic Origin

Yes No

If "Submit" is clicked and there are fields with invalid data or required fields that were not answered, those fields will become red lettered. There will also be a list of helpful error messages at the top of the page.

If this happens, simply enter the correct information and click "Submit" again.

Printing Options

Determination Status: ***** PENDED *****

Inquiry: 11182009-6066172-020000

Provider ID 299084	Subscriber Name GARY JONES	Subscriber ID 748159263
Provider Alternate ID 0204	Consumer Name GARY JONES	Consumer ID 748159263
Provider Name & Address HEALTH CENTER JANET WATTLES MENTAL 526 W STATE ST ROCKFORD IL 61101-1214	Consumer DOB 01/01/1985	

Pended Application
01-111809-1-4-1

Application Date
11/18/2009

Application Type
PSH - PERMANENT SUPPORTIVE HOUSING

Attached Documents

Document Title	Document Description
Clinical Test Document.doc	Secure-Clinical Document - PCRF501
Non Clinical Test.doc	Web Attachment - PCRF507

Application Printing Options
(For the best print results, please print in 'Landscape' format)

Print Application Result <i>Click to print the entire Special Program Application</i>	Print Signature Page <i>Click to print the signature page</i>	Print Results <i>Click to print the Results (this) page</i>
Return to Provider Home <i>Click to return to the ProviderConnect home page</i>		

Once the application is submitted successfully, the Determination Status page will appear.

As stated on the application, the Signature Page must be printed, signed and faxed to the Collaborative within one business day of submitting an application. **If not, the application will be voided.**

There are also print functions for the purpose of your internal use.

This will return you to the Provider Home Page.

View a Submitted Application in ProviderConnect

The screenshot shows the ProviderConnect website interface. On the left is a navigation menu with items like Home, Specific Member Search, Register Member, etc. The main content area has a welcome message and a list of actions under 'WHAT DO YOU WANT TO DO TODAY?'. A red circle highlights 'Specific Member Search (eligibility, benefits, claims, authorizations)' in the list. A blue callout box points to this link with the text: 'To view a previously submitted application, click either of these two links.' Below the list are icons for 'INBOX' and 'SENT', and a message stating 'Your Recent Inquiries box is empty'.

Home

Specific Member Search

Register Member

Authorization Listing

Enter an Authorization Request

View Clinical Request Drafts

Claim Listing and Submission

Enter a Special Program Application

EDI Homepage

On Track Outcomes

Reports

My Online Profile

My Practice Information

Provider Data Sheet

Compliance

Handbooks

Forms

Network Specific Information

Education Center

Welcome ILLINOIS TEST PROVIDER. Thank you for using ValueOptions ProviderConnect.

WHAT DO YOU WANT TO DO TODAY?

- ▶ **Specific Member Search (eligibility, benefits, claims, authorizations)**
- ▶ Register Member
- ▶ Review Claims
- ▶ Enter a Claim
- ▶ Review an Authorization
- ▶ Enter an Authorization Request
- ▶ View Clinical Request Drafts
- ▶ View My Recent Provider Summary Vouchers
- ▶ Enter a Special Program Application

CLINICAL SUPPORT TOOLS

- ▶ View My Outcomes with On Track

NEWS & ALERTS

INBOX

SENT

Your Recent Inquiries box is empty

To view a previously submitted application, click either of these two links.

View a Submitted Application in ProviderConnect (continued)

Demographics | Enrollment History | COB | Benefits | Additional Information

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Consumer?		Eligibility	
Consumer ID	748159263	Effective Date	07/01/2008
Alternate ID		Expiration Date	
Consumer Name	JONES, GARY	COB Effective Date?	
Date of Birth	01/01/1985	View Funding Source Enrollment Details	
Address	1 FAKE ST CHICAGO, IL 60606		
Alternate Address			
Marital Status	-		
Home Phone			
Work Phone			
Relationship	1		
Gender	M - Male		

Subscriber	
Subscriber ID	748159263
Subscriber Name	JONES, GARY

To view a previously submitted PSH application, click "Special Program Applications".

View Consumer Auths	View Consumer Claims	View Empire Claims	View GHI-BMP Claims	View Consumer Registrations
Enter Auth Request	Enter Claim	Send Inquiry	View Clinical Request Drafts	Special Program Applications

View a Submitted Application in ProviderConnect (continued)

Demographics Enrollment History COB Benefits Additional Information

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Consumer?		Eligibility	
Consumer ID	748159263	Effective Date	07/01/2008
Alternate ID		Expiration Date	
Consumer Name	JONES, GARY	COB Effective Date?	
Date of Birth	01/01/1985	View Funding Source Enrollment Details	
Address	1 FAKE ST CHICAGO, IL 60606	Subscriber	
Alternate Address		Subscriber ID	
Marital Status	-	Subscriber Name	
Home Phone			
Work Phone			
Relationship	1		
Gender	M - Male		

View Consumer Auths View GHI-BMP Claims View Consumer Registrations

Enter Auth Request Enter Claim Send Inquiry View Clinical Request Drafts Special Program Applications

Enter a Special Program Application

Application Type	Date Application Submitted	Application Status	Appeal
MFP	11/03/2009		
MFP	11/03/2009		
PSH	11/18/2009		

There is an appeal process for PSH applications.

If there is an appeal on file that has not been determined, then the "Appeal" field will populate with 'Pending'. If all appeals on file have been determined, as approved or denied, the "Appeal" field will populate with 'Closed'.

Click the PSH application you wish to view.

Once the application has been clinically reviewed, the "Application Status" field will populate with 'Approved' or 'Denied'.

View a Submitted Application in ProviderConnect (continued)

Close Print

Special Program Application

Application Number 01-111809-1-4-1	Application Date 11/18/2009	Application Type PSH	Consumer Name GARY JONES	Provider Name HEALTH CENTER JANET WATTLES MENTAL	Provider Alternate ID
			Consumer ID 748159263	Provider ID 299084	

Intake Request Date
(applicable for PSH application only) (MMDDYYYY)
11/17/2009

Section 1: Applicant (Head of Household) Information

Phone # 111 222 3333	Mobile #
Work #	Pager #
Email	Fax #

*Race

<input checked="" type="checkbox"/> White	<input checked="" type="checkbox"/> Black or African American
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> American Indian or Alaskan Native	<input checked="" type="checkbox"/> Asian and White
<input type="checkbox"/> American Indian/Alaskan Native and White	<input type="checkbox"/> American Indian/Alaskan Native and Black
<input type="checkbox"/> Black (African American) and White	<input type="checkbox"/> Other

The entire application can now be viewed or printed. To print, click the "Print" button at the top of the page.

Technical Problems??

- ▶ EDI Help Desk (888) 247-9311
7 AM To 5 PM CST (Mon - Fri)
 - Examples of Technical Problems:
 - Account disabled or forgot password
 - System “freezing” or crashing
 - System unavailable errors

- ▶ If questions regard the content of the application, you may contact Lindsay Huth at (312) 814-4822.

