

# MFP and RR

## Electronic Application Process

Presenter and Author: Terry Schoonover

Summary:

This document will step through the process of submitting an electronic application for Money Follows the Person and Rapid Re-integration through the use of ProviderConnect.

Created on 1/7/2010

# Glossary of Terms

- ▶ MFP – Money Follows the Person
- ▶ RR – Rapid Re-integration

# Preparing to Submit an MFP or RR Electronic Application

- ▶ Before submitting an MFP or RR electronic application
  - Consumers must be registered with the Collaborative.
  - The only applications considered for processing are those from specific DMH Designated Transition Coordinators and Rapid Re-Integration Program Coordinators.

# Getting Started

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

The main content area is titled "Provider Online Services" and features a large image of two women. Below the image is the text "Provider Online Services". To the left of the main content is a sidebar menu with the following items:

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

The main content area contains a "Welcome to" message and a section titled "ProviderConnect". A blue box with the text "Log in to ProviderConnect" is overlaid on the text. Below this, there is a paragraph describing ProviderConnect: "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." To the right of this paragraph are three buttons: "LOG IN", "REGISTER", and "DEMO". A large red arrow points from the top of the "LOG IN" button area down to the "LOG IN" button.

Below the "ProviderConnect" section, there is a 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."

# Old 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 ILLINOIS TEST PROVIDER. Thank you for using ValueOptions ProviderConnect.**

WHAT DO YOU WANT TO DO TODAY?      YOUR MESSAGE CENTER

**The old home page is being reorganized as a part of a separate enhancement project. As of 1/29/2010, the new home page will have an updated look but will have the same functionality.**

- ▶ [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

 

**Your Recent Inquiries box is empty**

# New 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

ValueSelect Designation

Contact Us

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

YOUR MESSAGE CENTER

Click either link to enter an application for MFP or RR.

INBOX

SENT

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

- Eligibility and Benefits
  - Find Specific Member
  - Register Member
- Enter or Review Authorization Request
  - Enter an Authorization Request
  - Enter a Special Program Application**
  - Review an Authorization
  - View Saved Clinical Request Drafts
- Enter or Review Claims
  - Enter a Claim
  - Review Claims
  - View My Recent Provider Summary Vouchers
- View My Recent Authorization Letters

CLINICAL SUPPORT TOOLS

- View My Outcomes with On Track

# Disclaimer Page

## Disclaimer

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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. Information is provided by our clients.

**Consumer** <sup>?</sup>

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 <sup>?</sup>  
[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  
Consumer ID 748159263 Last Name 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: 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 functions.

### \*Application Type

Please only select the Special Program.

MONEY FOLLOWS THE PERSON

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 ID  
**748159263**

Last Name  
**JONES**

First Name  
**GARY**

Date of Birth (MMDDYYYY)  
**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.

MONEY FOLLOWS THE PERSON

### Provider

Tax ID	Provider ID <b>299084</b>	Provider Last Name <b>JANET WATTLES MENTAL</b>	Vendor ID <b>IL1000000</b>
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Last Name  
**JONES**

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.

## 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
- (NonClinical.xls) - Web Attachment - PCRF507

Back Next

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

City  State  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.

Only required for MFP applications.

Only required for RR applications.

# 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)

SELECT... 

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 at risk of Long Term Care admission due to the lack of community resources/residential alternatives?

Yes  No

Extended long-term (more than 6 months) patient in a State Psychiatric Hospital

Name of Hospital

Location of Hospital (City/State)

SELECT... 

An aging out adolescent or young adult in the Institutional Care Grant (ICG) program

ICG Location (City/State)

SELECT... 

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)

SELECT... 

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)

SELECT... 

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

For MFP or RR applications, either box 1 or 2 or 3 must be checked.

# Special Program Application

## Section 2 (continued)

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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/IL09/il.pdf>

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

These fields are required.

Yes  No

\*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.

None

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="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<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. The application will not be complete until all documents are submitted.

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

Intakes do not pertain to MFP or RR applications.

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.

### 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 contact my care manager and other individuals that may be required to facilitate my application for Access and Choice and/or the Permanent Supportive Housing Bridge Subsidy. I agree to complete additional information to determine my eligibility for DMH Bridge Subsidy. I agree to complete additional 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.

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

All four name and date fields are required.

Intakes do not pertain to MFP or RR applications.

# 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)

#### Section 1: Applicant (Head of Household) Information

Phone #

  

Work #

   Ext 

Email

Fax #

  

\*Race

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> White                            | <input 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 checked="" type="checkbox"/> Black/African American and White | <input type="checkbox"/> Other <input type="text"/>                |

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:**

\*\*\*\*\* **PENED** \*\*\*\*\*

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

Inquiry: 12082009-6066420-040000

Provider ID  
**299084**

Subscriber Name  
**GARY JONES**

Subscriber ID  
**748159263**

Provider Alternate ID  
**0204**

Consumer Name  
**GARY JONES**

Consumer ID  
**748159263**

Consumer DOB  
**01/01/1985**

Provider Name & Address  
**HEALTH CENTER JANET WATTLES MENTAL  
526 W STATE ST  
ROCKFORD IL 61101-1214**

Pended Application  
**01-120809-1-14-1**

Application Date  
**12/08/2009**

Application Type  
**MFP - MONEY FOLLOWS THE PERSON**

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.

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

## Attached Documents

Document Title  
Clinical Test  
Document.doc  
NonClinical.xls

Document Description  
Secure-Clinical Document - PCRF501  
Web Attachment - PCRF507

## Application Printing Options

*(For the best print results, please print in 'Landscape' format)*

**Print Application Result**

**Print Signature Page**

**Print Results**

*Click to print the entire Special Program Application*

*Click to print the signature page*

*Click to print the Results (this) page*

This will return you to the Provider Home Page.

**Return to Provider Home**

*Click to return to the ProviderConnect home page*

# View a Submitted Application in ProviderConnect

The screenshot shows the ProviderConnect website interface. On the left is a vertical navigation menu with the following items: Home, Specific Member Search (circled in red), 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, ValueSelect Designation, and Contact Us. The main content area has a header: "Welcome ILLINOIS TEST PROVIDER . Thank you for using ValueOptions ProviderConnect." Below this is a "YOUR MESSAGE CENTER" section with an "INBOX" icon and a "SENT" icon. A message box states "Your Recent Inquiries box is empty". Under the heading "WHAT DO YOU WANT TO DO TODAY?", there are several menu items. Under "Eligibility and Benefits", the item "Find Specific Member" is circled in red. Other items include "Register Member", "Enter or Review Claims" (with sub-items: "Enter a Claim", "Review Claims", "View My Recent Provider Summary Vouchers"), "Enter or Review Authorization Request" (with sub-items: "Enter an Authorization Request", "Enter a Special Program Application", "Review an Authorization", "View Saved Clinical Request Drafts"), and "View My Recent Authorization Letters". At the bottom, under "CLINICAL SUPPORT TOOLS", there is a link for "View My Outcomes with On Track". A blue callout box with a red arrow pointing to the "Find Specific Member" link contains the text: "To view a previously submitted application, click either of these two links." Another red arrow points from the "Specific Member Search" link in the navigation menu to the same callout box.

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](#)

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

YOUR MESSAGE CENTER

 INBOX

 SENT

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

- Eligibility and Benefits
  - [Find Specific Member](#)
  - [Register Member](#)
- Enter or Review Claims
  - [Enter a Claim](#)
  - [Review Claims](#)
  - [View My Recent Provider Summary Vouchers](#)
- Enter or Review Authorization Request
  - [Enter an Authorization Request](#)
  - [Enter a Special Program Application](#)
  - [Review an Authorization](#)
  - [View Saved Clinical Request Drafts](#)
- [View My Recent Authorization Letters](#)

CLINICAL SUPPORT TOOLS

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

# Search A Member

- 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

## 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.

*Consumer 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="12082009"/>	(MMDDYYYY)
<input type="button" value="Search"/>		

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

# 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?

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**

To view a previously submitted MFP or RR 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?	<a href="#">View Funding Source Enrollment Details</a>
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		

Subscriber	
Subscriber ID	748159263

Click the MFP or RR application you wish to view.

There is not an appeal process for MFP or RR applications. This section will not display any information for these application types.

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

Enter a Special Program Application

Application Type	Date Application Submitted	Application Status	Appeal
<a href="#">MFP</a>	11/03/2009		
<a href="#">MFP</a>	11/03/2009		
<a href="#">PSH</a>	11/18/2009		
<a href="#">MFP</a>	12/08/2009		
<a href="#">MFP</a>	12/08/2009		
<a href="#">RR</a>	12/08/2009		

# View a Submitted Application in ProviderConnect (continued)

Close Print

**Special Program Application**

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Application Number <b>01-120809-1-24-1</b>	Application Date <b>12/08/2009</b>	Application Type <b>MFP</b>	Consumer Name <b>GARY JONES</b>	Provider Name <b>HEALTH CENTER JANET WATTLES MENTAL</b>	Provider Alternate ID <b>0204</b>
			Consumer ID <b>748159263</b>	Provider ID <b>299084</b>	

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

Section 1: Applicant (Head of Household) Information

Phone # <b>111 111 1111</b>	Mobile #
Work # <b>222 222 2222 222</b>	Pager #
Email <b>email@email.com</b>	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 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.

# Where to Find this Document for Future Reference

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- ▶ [http://www.illinoismentalhealthcollaborative.com/provider/prv\\_information.htm](http://www.illinoismentalhealthcollaborative.com/provider/prv_information.htm)
  - The link will be named Money Follows the Person and Rapid Re-integration Training (1 / 8 / 10) and will be found in the “Training” section of the page.