

Michigan Department of Health and Human Services
HOME HELP BILLING FOR HOSPITAL ADMISSION DATE

A Home Help provider may be paid for services on the day the Home Help client was admitted to a hospital if:

- The services were provided on or after February 1, 2023.
- The services were provided before the time the Home Help client was admitted to the hospital.
- The services were provided in the Home Help client's home or workplace. **NOTE:** Laundry and shopping authorized to be done outside the Home Help client's home may be eligible for payment if completed before the time the Home Help client was admitted to the hospital.
- The Home Help client has active Medicaid.
- The provider logs the tasks they provided on the service verification. Individual caregivers must log the tasks on the Electronic Service Verification (ESV) or Paper Service Verification (PSV). Agency providers must log the tasks on the MSA-1904 Home Help Agency Invoice.
- The provider fills out, signs and dates this form and sends it to the Home Help client's adult services worker or local MDHHS office within 365 days of the date of service.

How to Complete and Submit this Form

SECTION 1: Fill in the Home Help client's first and last name. Fill in the Home Help client's Medicaid identification (ID) number if available.

SECTION 2: Fill in the Home Help provider's information. An individual caregiver fills in their first and last name and provider ID number. A Home Help agency provider fills in:

- The name of the agency.
- The agency's provider ID number.
- The first and last name of the agency caregiver who provided services to the Home Help client on the hospital admission date.
- The agency caregiver's provider ID number.

SECTION 3: Fill in the date and time the services were provided, including:

- The date the Home Help client was admitted to the hospital.
- The time Home Help services began and the time Home Help services ended. Times must be recorded in an hh:mm format. "AM" or "PM" must be checked.

SECTION 4: This section must only be signed by an individual caregiver employed by the Home Help client or an authorized Home Help agency representative. An authorized Home Help agency representative is a person who is authorized to act on behalf of the agency owner. The signature must be handwritten.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: Title XIX of the Social Security Act and Administrative rule 400.1104(a)
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

**HOME HELP BILLING FOR HOSPITAL
ADMISSION DATE**

Michigan Department of Health and Human
Services

Case Log Number
Local MDHHS Office
Adult Services Worker Name
Adult Services Worker Email Address

SECTION 1 – Home Help Client Information

Home Help Client Name	Medicaid ID Number

SECTION 2 - Home Help Provider Information

Individual Caregiver or Agency Provider Name	Provider ID Number
For Agency Providers Only:	
Name of Agency Caregiver Who Provided Services	Provider ID Number

SECTION 3 – Date and Time Home Help Services Were Provided

Date of Hospital Admission	Time Home Help Services Began		Time Home Help Services Ended			
	hh:mm	AM <input type="checkbox"/>	PM <input type="checkbox"/>	hh:mm	AM <input type="checkbox"/>	PM <input type="checkbox"/>

NOTE: TO BE ELIGIBLE FOR PAYMENT, THE SERVICES PROVIDED ON THIS DATE MUST BE LOGGED ON THE HOME HELP PROVIDER'S SERVICE VERIFICATION.

SECTION 4 – Attestation

By signing below, I affirm that:	
<ul style="list-style-type: none">The information above and on the service verification is correct and true. The provider listed in Section 2 of this form provided the services before the time the Home Help client was admitted to the hospital.I know that billing for services that were not provided is fraud. I know it could result in provider termination or suspension from Medicaid programs; recoupment of the funds paid for the services; and criminal conviction. A criminal conviction could result in a fine up to \$50,000 and a prison sentence of four to ten years for each count.I know that all information contained in this form is confidential and remains the property of MDHHS. I agree to maintain the confidentiality of any information provided to me by MDHHS and will follow all applicable state or federal laws concerning the confidentiality of the information therein. I will use appropriate safeguards to prevent unauthorized use or disclosure of the information contained in this form. If there is an unauthorized disclosure of the confidential information contained in this form or if this form is lost or stolen, I will contact the appropriate MDHHS staff member for further assistance within 24 hours of the unauthorized disclosure, lost, or theft becoming known to me.	
Individual Caregiver or Authorized Agency Representative Signature	Date Signed