Michigan Department of Health and Human Services

HOME HELP AGENCY INVOICE

Instructions for Completing the Home Help Agency Invoice

**NOTE: Total time billed must not exceed the agency provider’s approved Time and Task amount. Authorized payments will not include billed time in excess of the approved amount.**

1. The agency provider completes the following sections of the Home Help Agency Invoice to document the provision of personal care services for each day in the month and year indicated.
2. **BILLING INFORMATION**
3. **AGENCY NAME:** Enter the complete name of the agency provider.
4. **AGENCY PROVIDER NUMBER:** Enter the CHAMPS ID number of the agency provider.
5. **AGENCY PHONE NUMBER:** Enter the phone number where the agency representative can be reached.
6. **CONTACT PERSON:** Enter the first and last name of the agency representative.
7. **BILLING PERIOD:** Enter the Billing Month and Year (MM/YYYY).
8. **DATE SUBMITTED:**  Enter the date the invoice is submitted to the client’s local county MDHHS office (MM/DD/YYYY).
9. **HOURLY RATE:** Enter the agency provider's MDHHS-approved hourly rate for the client.
10. **CLIENT NAME:** Enterthe first and last name of the client.
11. **CLIENT MEDICAID ID NUMBER:** Enter the client’s Medicaid Identification Number.
12. **BILL TO:** Enter the name of the client’s local county MDHHS office.
13. **ATTENTION:** Enter the name of the client’s adult services worker.
14. **VERIFICATION OF SERVICES AND HOSPITAL/NURSING FACILITY STAYS**
15. For each day of the billing month, check all the approved tasks completed.
16. If the client stayed in a hospital or nursing facility, check the day(s) the client was admitted, the day(s) the client stayed in the facility and the day(s) the client was discharged.
17. When Laundry is checked and was completed at a laundry facility, check Travel Time for Laundry. When Shopping is checked and required travel to one or more stores, check Travel Time for Shopping. **NOTE**: The frequency of travel must not exceed the agency provider’s approved Time and Task amount.
18. Enter total hours and minutes of service provision in the Total Time for Services Above field.
19. **VERIFICATION OF COMPLEX CARE TASKS:** For each day of the billing month, check all the approved tasks completed. Enter total hours and minutes of service provision in the Total Time for Services Above field. **NOTE**: Complete only if complex care tasks were provided.
20. **TOTAL TIME FOR BILLING PERIOD:** Add together the times in the Total Time for Services Above and the Total Time from the Previous Page fields. Record the total time in hours and minutes. **NOTE**: Complete only if complex care tasks were provided.
21. **SIGNATURE OF AUTHORIZED REPRESENTATIVE / DATE:** Sign and date the invoice to certify provision of the approved tasks. **NOTE:** If complex care tasks were provided, sign and date both pages of the invoice.
22. The agency provider sends the completed Home Help Agency Invoice to the client’s local county MDHHS office – Attention: Adult Services Unit. The invoice should not be submitted before the last day of the services billing period. The invoice must be submitted to the Adult Services Unit of the client’s local county MDHHS office **no later than** 365 days from the service date. **Failure to submit the invoice within 365 days of the service date will result in non-payment.**

**APPROVED PERSONAL CARE TASKS**

**NOTE:** Approved time for items 1 through 13 is for hands-on care only.

1. **Eating/Feeding –** helping with use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, cleaning face and hands, as needed after a meal.
2. **Toileting –** helping on/off toilet, commode/bed pan, emptying commode/bed pan, managing clothing, wiping and cleaning body after toileting, cleaning ostomy and/or catheter tubes/receptacles, applying diapers and disposable pads; may include doing catheter, ostomy or bowel programs.
3. **Bathing –** helping with cleaning the body or parts of the body, shampooing hair, using tub or shower, sponge bathing, including getting a basin of water, managing faucets, soaping, rinsing and drying.
4. **Grooming –** helping to maintain personal hygiene and neat appearance, including hair combing, brushing, oral hygiene, shaving, fingernail and toe nail care (unless a physician advises not to do so).
5. **Dressing –** helping with putting on/taking off, fastening/unfastening garments/undergarments, special devices such as back/leg braces, corsets, artificial limbs or splints.
6. **Transferring –** helping to move from one position to another, such as from a bed to a wheelchair or sofa, to come to a standing position and/or repositioning to prevent skin breakdown.
7. **Mobility –** helping with walking or moving around inside the living area, changing locations in a room, moving from room to room or climbing stairs.
8. **Medication –** helping with administering prescribed or over-the-counter medication.
9. **Meal Preparation –** helping with planning menus, washing, peeling, slicing, opening packages, cans and bags, mixing ingredients, lifting pots/pans, reheating food, cooking, operating stove/microwave, setting the table, serving the meal, washing/drying dishes and putting them away.
10. **Shopping –** helping to compile a list identifying needed items, picking up items at the store, managing cart/baskets, transferring items to home and storing them away.
11. **Laundry –** helping by getting laundry to machines, sorting, handling soap containers, placing laundry into machines, operating machine controls, handling wet laundry, drying, folding and storing laundry.
12. **Light Housework –** helping with sweeping, vacuuming, washing floors, washing kitchen counters and sinks, cleaning the bathroom, changing bed linen, taking out trash, dusting and picking up, bringing in fuel for heating/cooking purposes if necessary.
13. **Complex Care tasks –** require special techniques/knowledge; may replace most or all 1-9 tasks when approved by specialist. Complex care tasks include bowel program, catheter or leg bags, colostomy care, eating or feeding assistance, peritoneal dialysis, range of motion exercises, specialized skin care, suctioning and wound care.

**INSTRUCTIONS FOR ADULT SERVICES WORKER**

1. When the invoice is returned, review for accuracy. If invoice is correct, authorize payment.
2. Resolve inaccuracies immediately. Once invoice is corrected, authorize payment.
3. Maintain the invoice in the client’s case record.

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| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability. |
| **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. |

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| HOME HELP AGENCY INVOICE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Michigan Department of Health and Human Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Contact Person | | | | | | | | | | | | | Billing Period | | | | | | | | | | | | | | Date Submitted | | | | | | | | | Hourly Rate | | | | |
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| Client Name: | | | | | |  | | | | | | | | | | | Client Medicaid ID Number: | | | | | | | | | | | | | | | | |  | | | | | | |
| Bill To: | | <Enter client's local county MDHHS office> | | | | | | | | | | | | | | | | | Attention: <Enter client's adult services worker> | | | | | | | | | | | | | | | | | | | | | |
| **Verification of services and hospital/nursing facility stays** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Days of Billing Month | | | Bathing | | Dressing | | | Eating | | Grooming | | Mobility | | Toileting | | Transferring | | | | | Housework | Laundry | | Travel Time for Laundry | | | | | | | Medication | | Meal Preparation | | | | Shopping | Travel Time for Shopping | | Hospital/Nursing Facility Stay |
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| **Total Time for Services Above:** <Enter hh:mm>  I certify that has provided all the services as checked above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <Enter Signature of Authorized Representative> | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | <Enter Date> | | | | | | | | | | |
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| Client Name | | | | | | | | | Adult Services Worker Name | | | | | | | | | | | | | | | | Billing Period | | | | | | | | | | | | | | | |
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| HOME HELP AGENCY INVOICE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **verification of Complex Care tasks** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Days of Billing Month | | | | Bowel Program | | | Catheters for Leg Bags | | | | Colostomy Care | | | | Eating or Feeding Assistance | | | | | Peritoneal  Dialysis | | | Range of Motion Exercises | | | | | | | | | Specialized Skin Care | | | Suctioning | | | | Wound Care | |
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| **Total Time for Services Above:** <Enter hh:mm>  **Total Time from Previous Page:** <Enter hh:mm>  **Total Time for Billing Period:**  <Enter hh:mm> | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | |
| I certify that has provided all the services as checked above. | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | |
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