

ACT 22

COMPASS COMMUNITY PARTNERS

COMPASS COMMUNITY PARTNERS

- **GETTING STARTED**
- **SIGN UP FOR THE COUNTY JAIL TO BE A COMPASS COMMUNITY PARTNER**
- **WILL NEED TO ESTABLISH A**
 - **Log in ID**
 - **Password**

BENEFITS OF ACT 22

SUBSTANTIAL SAVINGS FOR COUNTY JAILS

- **INPATIENT HOSPITAL CHARGES WILL BE REIMBURSED WITH MEDICAID FEES (a Medicare DRG will be assigned)**
- **OUTPATIENT CHARGES WILL BE REIMBURSED USING MEDICARE FEES**

WHAT YOU NEED TO KNOW

- COMPASS APPLICATION IS TO BE FILED WHEN
 - INMATE RETURNS TO THE PRISON/JAIL FROM AN INPATIENT HOSPITALIZATION
- OUTPATIENT CHARGES
 - a. REPRICED USING MEDICARE FEES
 - a. AMBULANCE FEES TRANSPORTING THE INMATE FROM JAIL TO HOSPITAL REGARDLESS IF INMATE HAS AN “ER” VISIT OR IS ADMITTED

INFORMATION NEEDED TO FILE THE COMPASS APPLICATION

- **INMATE NAME**
- **DATE OF BIRTH**
- **SOCIAL SECURITY NUMBER**
- **MARITAL STATUS OF INMATE**
- **DATES OF INPATIENT STAY**

COUNTY
PRISON
INPATIENT
ELIGIBILITY
FORM

COMPLETED
BY
YOUR
"SICKLINE"
PHYSICIAN

COMPASS E-FORM NUMBER
COUNTY PRISON NAME

CAO/CU USE ONLY - CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE
WORKER				

Pennsylvania Department of Public Welfare
COUNTY PRISON INPATIENT ELIGIBILITY FORM

APPLICANT'S INFORMATION			
NAME	BIRTH DATE	INMATE NUMBER	SOCIAL SECURITY NUMBER
COUNTY PRISON ADDRESS			CONTACT PHONE NUMBER

TO BE COMPLETED BY MEDICAL PROVIDER (must be a licensed physician, physician's assistant, certified nurse practitioner or psychologist)

I. DIAGNOSIS OF MEDICAL CONDITION: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please provide estimated due date _____ Appropriate clinical information must be on file at the county prison, such as History and Physical (H&P), discharge summary, progress notes, x-rays, labs to verify the condition is/was an emergency.	SSA DISABILITY CRITERIA CATEGORIES Check all that apply: (See Reverse Side)															
	<table border="0"> <tr> <td>Musculoskeletal <input type="checkbox"/></td> <td>Visual/Speech <input type="checkbox"/></td> </tr> <tr> <td>Respiratory <input type="checkbox"/></td> <td>Cardiovascular <input type="checkbox"/></td> </tr> <tr> <td>Digestive <input type="checkbox"/></td> <td>Renal Disorders <input type="checkbox"/></td> </tr> <tr> <td>Hematological <input type="checkbox"/></td> <td>Skin Disorders <input type="checkbox"/></td> </tr> <tr> <td>Endocrine <input type="checkbox"/></td> <td>Multiple Systems <input type="checkbox"/></td> </tr> <tr> <td>Neurological <input type="checkbox"/></td> <td>Malignancy <input type="checkbox"/></td> </tr> <tr> <td>Immune Sys. <input type="checkbox"/></td> <td>Mental Disorders <input type="checkbox"/></td> </tr> <tr> <td colspan="2">None of the Above Apply <input type="checkbox"/></td> </tr> </table>	Musculoskeletal <input type="checkbox"/>	Visual/Speech <input type="checkbox"/>	Respiratory <input type="checkbox"/>	Cardiovascular <input type="checkbox"/>	Digestive <input type="checkbox"/>	Renal Disorders <input type="checkbox"/>	Hematological <input type="checkbox"/>	Skin Disorders <input type="checkbox"/>	Endocrine <input type="checkbox"/>	Multiple Systems <input type="checkbox"/>	Neurological <input type="checkbox"/>	Malignancy <input type="checkbox"/>	Immune Sys. <input type="checkbox"/>	Mental Disorders <input type="checkbox"/>	None of the Above Apply <input type="checkbox"/>
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None of the Above Apply <input type="checkbox"/>																

II. MEDICAL TREATMENT: Please list the emergency medical treatment needed for each diagnosis.

III. TREATMENT DATES:	BEGIN DATE	END DATE

IV. HOSPITAL INFORMATION:		
HOSPITAL NAME	HOSPITAL MA PROVIDER NUMBER	HOSPITAL PHONE NUMBER
HOSPITAL ADDRESS		

As County Prison Medical staff, I certify that all of the information provided on this form is true and correct to the best of my professional knowledge. I understand and agree that the diagnosis and supporting documentation may be subjected to review by the Department of Public Welfare.

County Prison Health Care Official Signature

County Prison Health Care Official (Please Print)	DATE	E-MAIL ADDRESS	TELEPHONE NUMBER

(For more information see reverse side)

MA Form County Prison Draft 9/14/2011

GUIDELINES

SSA

DISABILITY

CRITERIA

CATEGORY

IMPAIRMENTS

SSA Disability Criteria Category Impairments

Musculoskeletal: Major dysfunction of any joint; Reconstructive surgery/surgical arthrodesis of a major weight bearing joint; Disorders of the spine resulting in nerve root compression, arachnoiditis, or stenosis; Amputation of hands, extremities, or hemipelvectomy/hip disarticulation; Fracture of femur, tibia, pelvis or tarsal bones with nonunion and inability to ambulate; Fracture of upper extremity with nonunion; Soft tissue injury with impairment of major function > 12 months

Visual/Speech: **BLIND**= Loss of visual acuity with residual acuity in better eye <20/200; Contraction of visual field in better eye; Loss of visual efficiency with better eye 20% or less after best correction; Disturbance of labyrinthine-vestibular function; Loss of speech; **DEAF**= Hearing loss threshold >90DB Air or 60DB Bone +/- cochlear implant

Respiratory: Chronic pulmonary insufficiency; Asthma, poorly controlled; Cystic fibrosis; Pneumoconiosis; Bronchiectasis; Sleep-related breathing disorders; Lung transplant

Cardiovascular: Chronic heart failure; Ischemic heart disease; Recurrent arrhythmias; Symptomatic congenital heart disease; Heart transplant; Aneurysm of aorta or major branches; Chronic venous insufficiency; Peripheral arterial disease

Digestive: Gastrointestinal hemorrhage requiring blood transfusion; Chronic liver disease; Inflammatory bowel disease; Short bowel syndrome; Weight loss due to any digestive disorder; Liver transplantation

Renal: Impaired renal function-hemodialysis; transplantation; elevated creatinine; Nephrotic syndrome

Hematologic: Chronic anemia; Sickle cell disease or variant; Chronic thrombocytopenia; Hereditary telangiectasia; Coagulation defects; Polycythemia vera; Myelofibrosis; Chronic granulocytopenia; Aplastic anemia with bone marrow or stem cell transplantation

Skin Disorders: Ichthyosis; Bullous disease; Chronic infections of skin or mucous membranes; Dermatitis; Hidradenitis suppurativa; Genetic photosensitivity disorder; Burns

Endocrine: Disorders of pituitary; thyroid, parathyroid; adrenal; pancreatic glands; Complications of diabetes mellitus

Multiple Systems: Non-mosaic Down Syndrome

Neurological: Epilepsy-convulsive & non-convulsive; Central nervous system vascular accident; Benign brain tumors; Parkinsonian syndrome; Cerebral palsy; Spinal cord or nerve root lesion; Multiple sclerosis; Amyotrophic lateral sclerosis; Anterior poliomyelitis; Myasthenia gravis; Muscular dystrophy; Peripheral neuropathies; Subacute combined cord degeneration (Pernicious Anemia); Degenerative diseases (Huntington's Chorea, Freidrich's Ataxia); Cerebral trauma; Syringomyelia

Malignancy: Tumor of skin; soft tissue; bone; or other body organ/gland; Lymphoma; Leukemia; Multiple myeloma; Tumor of unknown origin; Tumor treated by bone marrow/stem cell transplantation

Immune System: Systemic lupus erythematosus; Systemic vasculitis; Systemic sclerosis (Scleroderma); Polymyositis and dermatomyositis; Undifferentiated & mixed connective tissue disease; Immune deficiency disorder; Human immunodeficiency disorder with infectious or non-infectious complication; Inflammatory arthritis; Sjögren's syndrome

Mental Disorders: Organic mental disorders; Schizophrenia & other psychotic disorders; Affective disorders; Mental retardation; Anxiety-related disorders; Somatoform disorders; Personality disorders; Substance addiction disorders; Autistic disorder & other pervasive developmental disorder

For Full text: <http://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm>

Central Unit Contact Information

(Preferred Method) Electronic Fax Number: 1-866-322-2678

E-mail: ra-scima@pa.gov

**COUNTY COMMISSIONERS ASSOCIATION OF
PENNSYLVANIA**

**VISIT CCAP'S WEBSITE
FOR A
TUTORIAL
ON
ACT 22**

CONTACT INFORMATION

CCAP

CHRISTIE WARD

CAPTIVE PROGRAMS MANAGER

717-526-1010

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PIMCC

COST MANAGEMENT PLUS, INC.

PIMCC PROGRAM ADMINISTRATOR

AND

ACT 22 LIAISON

1-800-552-2752

costmanagementplus@comcast.net