



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health  
Services

# NEWSLETTER

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Volume 9 No. 37

July 1999

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**TO:** Mental Health Clinics who Provide Partial Care Services -  
For Action

**SUBJECT:** **Partial Care Provider Questionnaire**

**EFFECTIVE:** Immediately

**BACKGROUND:** The New Jersey Medicaid and NJ KidCare programs recently announced a change in the procedure for obtaining prior authorization. Prior authorization requests are now being processed by Medicaid District Office staff.

**PURPOSE:** The purpose of this Newsletter is to advise Partial Care Independent Clinic Providers that the attached questionnaire must be completed. The questionnaire will be utilized by our staff to familiarize them with your facility, staff and programs.

**ACTION:** Please complete all sections of this questionnaire and provide all requested documentation for each and every individual site location. If you have not received a separate questionnaire for each facility, please copy this form and complete for each and every site. Please copy blank forms as needed and/or use additional sheets as necessary. The attached questionnaire and the requested documentation must be submitted by July 25, 1999, to:

State of New Jersey  
Division of Medical Assistance & Health Services  
Office of Beneficiary & Provider Services  
P. O. Box 712  
Trenton, New Jersey 08625-0712

If there are any questions concerning this Newsletter, please contact the Medicaid District Office that serves the county of your location. A list of Medicaid District Offices is attached.

Attachments: I. Facility Information

- II. Ownership Information
  - III. Additional Facilities
  - IV. Facility Transportation
  - V. Facility Staff
  - VI. Facility Programs
  - VII. Clients
- Medicaid District Office Directory

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB  
(BLUE TAB MARKED "5")**