Revision: HCFA-AT-81-37 (BPP)

State ALABAMA

Attachment 3.1-B
Page 1

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

Not in system
4/11/00
3.1B

State ALABAMA

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

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1. Inpatient hospital services other than those provided in an institution for mental diseases or tuberculosis
   - ☐ Provided
     - ☐ No limitations
     - ☐ With limitations*

2.a. Outpatient hospital services.
   - ☐ Provided
     - ☐ No limitations
     - ☐ With limitations*

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic
   - ☐ Provided
     - ☐ No limitations
     - ☐ With limitations*

3. Other laboratory and X-ray services.
   - ☐ Provided
     - ☐ No limitations
     - ☐ With limitations*

4.a. Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.
   - ☐ Provided
     - ☐ No limitations
     - ☐ With limitations*

* Description provided on attachment.

TN # 81-19
Supersedes
TN # _____

Approval Date 1-8-82 Effective Date 10-1-81

State ALABAMA

Attachment 3.1-B
Page 3

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

4.c. Family planning services and supplies for individuals of child-bearing age.

- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

   a. Podiatrists' Services

   - ☐ Provided
     - ☐ No limitations
     - ☐ With limitations*

* Description provided on attachment.

Tobacco Cessation Counseling Services for Pregnant Women

4. d 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician; and

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: No limitations With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

b. Optometrists' Services

☐ Provided

☐ No limitations

☐ With limitations*

c. Chiropracters' Services

☐ Provided

☐ No limitations

☐ With limitations*

d. Other Practitioners' Services

☐ Provided

☐ No limitations

☐ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☐ Provided

☐ No limitations

☐ With limitations*

b. Home health aide services provided by a home health agency.

☐ Provided

☐ No limitations

☐ With limitations*

* Description provided on attachment.

State ALABAMA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

c. Medical supplies, equipment, and appliances suitable for use in the home.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

8. Private duty nursing services.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

9. Clinic services.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

10. Dental services.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

11. Physical therapy and related services.

a. Physical therapy.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

b. Occupational therapy.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.
- ☐ Provided
  - ☐ No limitations
  - ☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

b. Dentures. ☐ Provided
☐ No limitations
☐ With limitations*

c. Prosthetic devices. ☐ Provided
☐ No limitations
☐ With limitations*

d. Eyeglasses. ☐ Provided
☐ No limitations
☐ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan.

a. Diagnostic services. ☐ Provided
☐ No limitations
☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

b. Screening services. ☐ Provided
☐ No limitations
☐ With limitations*

c. Preventive services. ☐ Provided
☐ No limitations
☐ With limitations*

d. Rehabilitative services. ☐ Provided
☐ No limitations
☐ With limitations*

14.a. Services for individuals age 65 or older in institutions for tuberculosis.

(1) Inpatient hospital services. ☐ Provided
☐ No limitations
☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

(2) Skilled nursing facility services. ☐ Provided
- ☐ No limitations
- ☐ With limitations*

(3) Intermediate care facility services. ☐ Provided
- ☐ No limitations
- ☐ With limitations*

14.b. Services for individuals age 65 or older in institutions for mental diseases.

(1) Inpatient hospital services. ☐ Provided
- ☐ No limitations
- ☐ With limitations*

(2) Skilled nursing facility services. ☐ Provided
- ☐ No limitations
- ☐ With limitations*

* Description provided on attachment.

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

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c. Intermediate care facility services.

/ / Provided / / No limitation / / With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

/ / Provided / / No limitation / / With limitations*

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

/ / Provided / / No limitation / / With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ / Provided / / No limitation / / With limitations*

17. Nurse-midwife services.

/ / Provided / / No limitation / / With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/ / Provided / / No limitation / / Provided in accordance with section 2302 of the Affordable Care Act

// With limitations*

*Description provided on attachment-

State ALABAMA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

17. Nurse-midwife services. ☐ Provided
    ☐ No limitations
    ☐ With limitations*

18. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

    a. Transportation ☐ Provided
       ☐ No limitations
       ☐ With limitations*

    b. Services of Christian Science Nurses ☐ Provided
       ☐ No limitations
       ☐ With limitations*

    c. Care and services provided in Christian Science sanitoria ☐ Provided
       ☐ No limitations
       ☐ With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): _____

d.	Skilled nursing facility services provided for patients under 21 years of age.	☐ Provided ☐ No limitations ☐ With limitations*
e.	Emergency hospital services	☐ Provided ☐ No limitations ☐ With limitations*
f.	Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of an R.N.	☐ Provided ☐ No limitations ☐ With limitations*

* Description provided on attachment.