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

1. Inpatient hospital services other than those provided in an institution for mental diseases..

   Provided: [ ] No limitations [X] With limitations* .

2.a. Outpatient hospital services.

   Provided: [ ] No limitations [X] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.

   [X] Provided [ ] No limitations [X] With limitations*

   [ ] Not Provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the Plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual ~~(HCFA-Pub. 45-4)~~.

   Provided: [~~X~~] No limitations [X] With limitations*

3. Other laboratory and x-ray services.

   Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

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2.b. Rural health clinic services and other ambulatory services furnished by rural health clinic

Provided within limits of other providers for the same services and limited to services specified in certification.

3.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by an FQHC

Limited to four (4) visits per month for adults. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis.