APPLICATION FOR MEDICAID CERTIFICATION
2021-2022

APPROVED
By Lindsey Kimbleton at 5:11 pm, Aug 14, 2021

SCHOOL DISTRICT:	Carroll County
SUPERINTENDENT:	Danny Osborne
LEA MEDICAID LIAISON:	Wayne Sizemore
ADDRESS:	813 Hawkins Street Carrollton, KY 41008
PHONE:	502-732-7070
FAX:	502-792-7073
E-MAIL:	frank.sizemore@carroll.kyschools.u

SERVICES TO BE PROVIDED (check all that apply)

_X__Nursing*
___Audiology*
_X__Speech/Language*
_X__Occupational Therapy*
_X__Physical Therapy*
___Behavioral Health Services*
___Incidental Interpreter*
_X__Assistive Technology Devices
___Respiratory Therapy*
___Transportation
___Orientation & Mobility*

*you must have a practitioner listed on KDEMED2A and current licensure attached to application.

STATE PROVIDER NUMBER: 21021019
Do you contract with a Third Party Billing Agent? YES
NATIONAL PROVIDER NUMBER 13268382136
Please list the name of this contractor: InfoHandler
Will your district be participating in SBHS Expansion? Yes __ No _X__

STAFF QUALIFICATIONS

Qualified professionals shall provide the above checked services. Attached is KDEMED2A (Practitioner List) which list person(s) to provide the services, their professional classification, and their appropriate certification/license number(s). Copies of licenses or certificates for the practitioners listed are to be attached. As applicable, KDEMED2B is attached as a statement from a qualified nurse confirming the training and supervision for the person(s) servicng as "Health aides."

DISTRICT ASSURANCES

REQUEST FOR PARTICIPATION AND PROVISION OF STATE MATCHING FUNDS FOR MEDICAID SERVICES:

As Superintendent of the above named school district, I hereby request this district to ____**begin** or __X___**continue** as a Medicaid provider for the School-Based Health Services and agree to:

1.0	provide the nonfederal share of costs associated with services for federal Medicaid reimbursement,
2.0	certify the expenditure of those funds prior to submission of a claim for reimbursement for School-Based Health Services, and
3.0	conform to policies and procedures established by the Kentucky Department of Education and the Kentucky Department for Medicaid Services for provision of match and reimbursement services.
4.0	enroll in the School-Based Administrative Claiming program according to current Medicaid approved State Plan Amendment.
5.0	I agree that all staff who submit claims for eligible Medicaid students for services according to their IEP will be included in the Direct Service Staff Pool List for the School-Based Administrative Claiming Random Moment Time Study. I understand that failure to include all staff in this Random Moment Time Study could result in my district having to repay Medicaid for reimbursement of claims submitted.

DISTRICT CERTIFICATION (shall be signed by the Superintendent for the application to be considered)

I hereby certify that:

1.0	the above named local district has been monitored within the last seven (7) years and found to be in compliance with regulations governing Exceptional Children programs (707 KAR Chapter 1) as listed in the Policies and Procedures Manual; or the district has taken actions deemed appropriate by the Kentucky Department of Education to correct deficiencies;
2.0	only Medicaid covered services provided to IDEA Medicaid eligible students with Medicaid covered services listed in their Individual Education Programs (Plan of Care) shall be submitted for reimbursement;
3.0	a copy of each professional's current license or certificate is on file in the district's central office;
4.0	appropriate nurse's certification statements are signed on the School District Health Aide List (KDEMED2B);
5.0	copies of signed/executed affiliation agreements/contracts are on file in the district's central office;
6.0	I assure that the Program shall be managed according to the Quality Assurance Document;
7.0	100% of the funds expended for Medicaid services are eligible State/local funds for Medicaid matching purposes. The district agrees to submit quarterly certification of state expenditures (MAP 735) to the Kentucky Department for Medicaid Services; and
8.0	I understand that any falsified information may result in immediate dismissal from the School-Based Health Services Medicaid program, that misconduct charges may be filed with appropriate agencies, and the Kentucky Department for Medicaid Services may seek recoupment of funds or other legal remedies

SUPERINTENDENT SIGNATURE

DATE: 8-5-21

Last Updated:05-20-2015

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SCHOOL-BASED HEALTH SERVICES
2021-2022 PRACTITIONER LIST

District Name: Carroll County

PRACTITIONER NAME			PRACTITIONER TITLE	PRACTITIONER MODIFIER	PRACTITIONER LICENSE or CERTIFICATION NUMBER	Employee I.D. Number
LAST NAME	FIRST NAME	MI				
Morgan	Lea		Occupational Therapist	GO	133894	106
Haake	Rebecca		Speech Language Pathologist	GN	XXXX8045	122
Overpeck	Jacquline		Physical Therapist	GP	7119	153
Scherer	Jan		Speech Language Pathologist	GN	XXXX1595	152
Lewis	Peyton		Speech Language Pathologist	GN	XXXX6708	165
Cole	Kara		Speech Language Pathologist	GN	XXXX8997	166
Rupard	Emily		Occupational Therapist	GO	174695	163
Griffey	Becky		Occupational Therapist Assistant	GOU3	243643	155
Martin	Michaela		Physical Therapist Assistant	GPU3	A03507	154

MEDICAID HEALTH AIDE LIST
2021-2022

District Name: Carroll County

PRACTITIONER NAME			TITLE	Employee I.D. Number
LAST	FIRST	MI		

I hereby certify that the PERSONS ON THIS LIST have received the appropriate training which qualifies them to perform delegated tasks listed in the IEP of an individual student.
I further certify that I supervise the employee and regularly review the techniques employed during delivery of service to ensure safe and quality services are being delivered.

SIGNATURE OF SUPERVISING NURSE

813 Hawkins Street
Carrollton, KY 41008
WORK ADDRESS

(Make additional copies as needed)