REQUEST FOR MEDICAID SBHS CERTIFICATION AMENDMENT

Please submit all amendments in GMAP under the SBHS Certification Amendment Form and send a notification to the Schoolbasedmedicaid@education.ky.gov and title the subject line "amendment"
REMINDER: Amendments can only be backdated 15 business days

Date of Request: School Year:
School District: Billing Agent:
Effective Date of Amendment: Medicaid Liaison Email:
Medicaid Liaison: Phone:
Does your district want to add Expanded Access? Yes__ No____

SERVICES: The school district requests to add the **additional** school-based health services: (check all that apply)

- ☐ Nursing
- ☐ Audiology
- ☐ Speech/Language
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Mental/Behavioral Health
- ☐ Incidental Interpreter
- ☐ Assistive Technology Devices
- ☐ Transportation
- ☐ Orientation and Mobility

The school district requests to **delete** the following school-based health services from the district's school-based health services program: (check all that apply)

- ☐ Nursing
- ☐ Audiology
- ☐ Speech/Language
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Mental/Behavioral Health
- ☐ Incidental Interpreter
- ☐ Assistive Technology Devices
- ☐ Transportation
- ☐ Orientation and Mobility

STAFF: The school district requests to amend the approved practitioner list to (If there are additions and deletions, please specify which person(s) are to be deleted from the program):

☐ **Delete** the practitioners listed from providing services in this district

Last Name, First Name and Middle Initial	Title	Practitioner Modifier	Practitioner License or Certification number

☐ **Add** the practitioners listed as qualified providers of services to students with IEPs. All appropriate current licenses and certificates are attached.

Last Name, First Name and Middle Initial	Title	Practitioner Modifier	Practitioner License or Certification number and expiration date	Employee I.D Number (3-digit)

QUALITY ASSURANCE: The district requests amendment of the Quality Assurance Program previously submitted. The proposed amendment is attached.

Superintendent or Medicaid Liaison (signature) Date

Medicaid Health Aide List

PRACTITIONER LAST NAME	PRACTITIONER FIRST NAME	MI	TITLE	Employee ID

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.

Supervising Nurse (signature) Date