**REQUEST FOR MEDICAID SBHS CERTIFICATION AMENDMENT**

**Please submit all amendments in *GMAP* under the SBHS Certification Amendment Form**

**REMINDER: Amendments can only be backdated 15 business days & all fields must be filled in or we will NOT process your amendment.**

**\*\*\*YOU MUST FILL IN ALL FIELDS BELOW OR YOUR AMENDMENT WON’T BE PROCESSED**

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  Mental/Behavioral Health

Audiology  Incidental Interpreter

Speech/Language  Assistive Technology Devices

Occupational Therapy  Transportation

Physical Therapy  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  Mental/Behavioral Health

Audiology  Incidental Interpreter

Speech/Language  Assistive Technology Devices

Occupational Therapy  Transportation

Physical Therapy  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

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| --- | --- | --- | --- |
| Last Name, First Name and Middle Initial | Title | Practitioner  Modifier | Practitioner License or  Certification number |
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**Add** the practitioners listed as qualified providers of services to students with IEPs. All appropriate current licenses and certificates are attached.

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| --- | --- | --- | --- |
| Last Name, First Name and Middle Initial | Title | Practitioner  Modifier | Practitioner License or  Certification number and expiration date |
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Superintendent or Medicaid Liaison (signature) Date

Medicaid Health Aide List

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| PRACTITIONER LAST NAME | PRACTITIONER FIRST NAME | MI | TITLE |
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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