



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST**

(Louisiana Medicaid Program)

**School-Based
Health Center**

(Enrollment packet is subject to change without notice)

School-Based Health Center CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit, in order to enroll in the Louisiana Medicaid Program as a provider for School-Based Health Center:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	<p>4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. (Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)</p> <p>Option 1 (preferred): Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.</p> <p style="text-align: center;">-or-</p> <p>Option 2 (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.</p>
<input type="checkbox"/> *	5. (If submitting claims electronically) Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form and Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited (deposit slips are not accepted) .
<input type="checkbox"/>	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (W-9 forms are not accepted) .
<input type="checkbox"/>	8. To report "Specialty" for this provider type on Section A of the PE-50 in the Basic Enrollment Packet, please refer to the attached listing of Specialty Types for SBHC providers.
<input type="checkbox"/> **	9. Completed PE-50 KIDMED Provider Enrollment Supplement Agreement (3 pages).
<input type="checkbox"/> **	10. Completed Retainer Agreement Medical Director (2 pages).
<input type="checkbox"/> **	11. KIDMED Certification Checklist and Attestation (5 pages).
<input type="checkbox"/> **	12. Completed Supplemental Provider Enrollment Agreement for SBHC providers form (1 page).
<input type="checkbox"/>	<p>13. Obtain and submit a letter from OPH-ASHP confirming certification requirements are met as one of the following (see the Supplement Provider Enrollment Agreement below for more details):</p> <p style="margin-left: 40px;">A. OPH-ASHI (Adolescent School Health Program funded)</p> <p style="margin-left: 80px;">or</p> <p style="margin-left: 40px;">B. Other – OPH Certified</p>
<input type="checkbox"/> **	14. List of individuals linking to the SBHC with this application (1 page). Only physicians and nurse practitioners are allowed to be linked to SBHC.
<input type="checkbox"/> **	15. Completed Group Link/Unlink and Working Relationship form for each Nurse Practitioner and/or Physician being linked, only if currently enrolled. (Full enrollment application will be needed for any Individual N.P. or M.D. who is not currently enrolled in Louisiana Medicaid.)
<input type="checkbox"/>	16. CLIA Certificate required.

***Forms are included in the Basic Enrollment Packet.**

****Forms are included here.**

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT.

ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS).

Please submit all required documentation to:

**Molina Medicaid Solutions
Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159**

Description of Specialty Types* For School-Based Health Center Providers

Specialty Types are defined by the amount of N.P./M.D. time:

- 7A - SBHC/NP Part Time**
No direct services by M.D.
N.P. direct services 20 hours less than 20 hours per week
 - 7B - SBHC/NP Full Time**
No direct services by M.D.
N.P. direct services 20 hours or more per week
 - 7C - SBHC/MD Part Time**
Direct services by M.D. less than 20 hours per week
 - 7D - SBHC/MD Full Time**
Direct services by M.D. 20 hours or more per week
 - 7E - SBHC/NP+MD Part Time**
Combined M.D. plus N.P. direct services less than 20 hours per week
 - 7F - SBHC/NP + MD Full Time**
Combined M.D. plus N.P. direct services 20 hours or more per week
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NOTE: R.N. services, if provided, must be under the direction of a N.P. or M.D.

***Please be sure you have indicated your specialty on Section A of the PE-50 Form found in the Basic Enrollment Packet.**

PE-50 KIDMED PROVIDER ENROLLMENT SUPPLEMENT AGREEMENT (Continued)

- 6. The provider agrees to provide screening services to Medicaid recipients under the age of 21 who are receiving diagnosis, treatment, and/or other health services reimbursed by Medicaid or to refer them to KIDMED to select a screening provider.
- 7. The provider agrees that the submission of a claim shall be certification that the specific KIDMED services for which payment is claimed were provided to the person identified as the recipient. The provider agrees to perform all aspects of the services in a KIDMED screening clinic. The provider agrees not to bill DHH unless all aspects of the screening are complete.
- 8. The provider agrees to maintain records necessary to disclose the extent of KIDMED services provided to recipients on whom claims have been filed for five years from the date of service. The provider also agrees to provide this information as requested to KIDMED or a DHH authorized representative and to cooperate with on-site reviews and other monitoring activities.
- 9. Publicly financed providers agree to use Medicaid funds received for these services solely for the provision and/or enhancement of health services to children. These Medicaid funds may be used for the direct provision of health services and to defray the administrative cost of providing health services to children.
- 10. The provider agrees to submit KIDMED claims within 60 days of the date of service for recipients under the age of 21.
- 11. The provider agrees to submit KIDMED claims using the KIDMED EPSDT Claim form or through approved electronic means to the Medicaid Fiscal Intermediary for payment.
- 12. The provider agrees to participate in KIDMED site visits and provider training.
- 13. The provider agrees to refer pregnant and postpartum recipients and children under the age of 5 to the Women, Infants, and Children Program (WIC) and promote participation in WIC.
- 14. The provider agrees to refer any suspected child abuse, neglect, and/or sexual abuse of recipients under the age of 21 promptly to the Office of Community Services in the parish where the recipient resides per Louisiana revised statute.
- 15. The provider agrees to refer eligible recipients and families who may present grievances which may arise from KIDMED services provided under this agreement to KIDMED and/or DHH.
- 16. Louisiana Medicaid agrees to reimburse the provider for KIDMED services covered by Medicaid in accordance with applicable statutes and regulations and the schedule of maximum fees for KIDMED services.
- 17. The effective date of this agreement shall be the date on which it is signed by Louisiana Medicaid.
- 18. This agreement may be terminated by either party 60 days after receipt of a written notice by the other party. The provider must continue to provide services and maintain documentation in accordance with established regulations.
- 19. The provider agrees to schedule appointments for recipients under 12 months of age.
- 20. The provider agrees to obtain KIDMED approval on marketing materials prior to distribution.
- 21. The provider agrees to inform DHH Provider Enrollment with any changes in personnel, locations, hours of operation, or other pertinent information.

I certify that the information provided on this form is true to the best of my knowledge.

Provider-Authorized Signature

Date

Please Print Name

For DHH Use Only:

Medicaid Director or Designee

Date

PE-50 KIDMED PROVIDER ENROLLMENT SUPPLEMENT AGREEMENT (Continued)

Complete the following on all physicians and/or nurse practitioners who are providing the services or who are affiliated with the provider. Please print and attach page(s) if necessary.

Name and Title: _____ License #: _____

Medicaid Provider #: _____ IRS#: _____ Social Security #: _____

List days of week and times of the day spent working at this KIDMED practice. Be specific: (i.e., Monday, 9a-4p, and Thurs. 2p-8p).

DAY	HOURS	DAY	HOURS
___ Mon.	_____	___ Fri.	_____
___ Tues.	_____	___ Sat.	_____
___ Wed.	_____	___ Sun.	_____
___ Thurs.	_____		

Name and Title: _____ License #: _____

Medicaid Provider #: _____ IRS#: _____ Social Security #: _____

List days of week and times of the day spent working at this KIDMED practice. Be specific: (i.e., Monday, 9a-4p, and Thurs. 2p-8p).

DAY	HOURS	DAY	HOURS
___ Mon.	_____	___ Fri.	_____
___ Tues.	_____	___ Sat.	_____
___ Wed.	_____	___ Sun.	_____
___ Thurs.	_____		

Name and Title: _____ License #: _____

Medicaid Provider #: _____ IRS#: _____ Social Security #: _____

List days of week and times of the day spent working at this KIDMED practice. Be specific: (i.e., Monday, 9a-4p, and Thurs. 2p-8p).

DAY	HOURS	DAY	HOURS
___ Mon.	_____	___ Fri.	_____
___ Tues.	_____	___ Sat.	_____
___ Wed.	_____	___ Sun.	_____
___ Thurs.	_____		

RETAINER AGREEMENT MEDICAL DIRECTOR

This agreement is entered into on this _____ day of _____ between _____, M.D., hereinafter referred to as MEDICAL DIRECTOR, of _____ KIDMED, hereinafter referred to as FACILITY.

WHEREAS the FACILITY desires to employ the services of MEDICAL DIRECTOR, and WHEREAS the MEDICAL DIRECTOR is desirous of offering certain services, it is therefore mutually agreed that the FACILITY does employ and the MEDICAL DIRECTOR agrees to provide his/her services to all patients without regard to race, color, creed, national origin, age, sex, religion, or handicap, under the following mutual terms and conditions:

MEDICAL DIRECTOR'S RESPONSIBILITIES

Supervise the overall functions of our facility's medical services in that the Medical Director shall:

1. Assume the administrative authority, responsibility, and accountability of overseeing our medical screening, policies, and procedures.
2. Coordinate plan of care and periodically review these planning and implement methods to keep the quality of care under constant surveillance.
3. Participate in the development of written policies, rules, and regulations to govern the medical screening and other health services provided. The medical director is responsible for seeing that these policies reflect an awareness of and provisions for meeting the needs of the patients.
4. Attend the recipient of services, once yearly under six years of age and every other year at age six and above.
5. Develop and participate in in-service training programs for nursing service and other related services.
6. Implement methods that assure continuous surveillance of the health status of employees including freedom from infection and routine health examinations.
7. Review written reports of surveys and inspections and make recommendations to the administrator.
8. Obtain and maintain during the term of this agreement a suitable professional liability and malpractice insurance policy.
9. Serve the facility as an independent contractor, it being understood and agreed that the MEDICAL DIRECTOR is not an employee of the facility.
10. Maintain the confidentiality of all patient information as established by our facility's policies and procedures.
11. Stay abreast of all other responsibilities required of a medical director as set forth in a Federal and State laws, statutes, or regulations as enacted or as may be enacted or amended.

QUALIFICATIONS

Medical Director certifies that he/she:

- 1. Is licensed to practice medicine in this state.
- 2. Has a Medical Degree from a college or university accredited by the American Medical Association.
- 3. Meets the requirements as set forth by these standards.
- 4. Maintains the required continuing education hours to assure continued competence.

DURATION OF AGREEMENT

- 1. The duration of this agreement is indefinite. However, either party may:
 - a) Terminate this agreement by providing the other party with a sixty (60) day written notice of such intent.
 - b) Terminate this agreement when either party fails to abide by its contents.
- 2. This agreement shall become null and void should the medical director/facility fail to meet the licensing requirements set forth by Federal and State statutes, laws, and regulations governing such services.

FACILITY’S RESPONSIBILITIES

The facility shall be responsible for:

- 1. Retaining the professional and administrative responsibility for all services provided by the MEDICAL DIRECTOR.
- 2. Making prompt payment for services rendered.

Assuring that the MEDICAL DIRECTOR has complete access to all records and supplies within the facility necessary for the performance of his/her duties.

Delegating the necessary administrative authority, responsibility, and accountability necessary for the MEDICAL DIRECTOR to perform his/her duties.

THE WITNESS THEREOF, the parties have duly set their hands and seal the day and year first above written:

WITNESS	DATE	MEDICAL DIRECTOR & LIC.	DATE
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WITNESS	DATE	FACILITY	DATE
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Supplemental Provider Enrollment Agreement For School-Based Health Center Providers

Guidelines for SBHC Provider:

1. The SBHC must be certified by the Office of Public Health, Adolescent School Health Program (OPH-ASHP) prior to applying for a Medicaid number. Documentation of this certification must be attached to the Medicaid Enrollment Application. The certification process involves the submission of written reports and an onsite visit every three years. In order to be certified through OPH-ASHP, the SBHC must meet all requirements of the Principles, Standards and Guidelines for SBHCs in Louisiana. This document is available at the OPH-ASHP website online at www.dhh.louisiana.gov/offices/?ID=255. If the SBHC does not maintain certification through OPH-ASHP, the Medicaid number will be revoked. For more information about this certification process visit the OPH-ASHP website.
2. The SBHC must be enrolled as a KIDMED screening provider in addition to enrollment for providing any other services.
3. The Individual Provider(s) linking to a SBHC must be individually enrolled in Louisiana Medicaid.
4. Coordinate and cooperate with the child's medical home (PCP) including submission of any relevant medical visit information to the PCP.
5. Bill all Medicaid services provided onsite under the SBHC Medicaid provider number.
6. Assure that a Registered Nurse only provides services under the direction of a Nurse Practitioner or Medical Doctor.
7. Agree to provide services under one of the specialty types listed on the PE 50 Form.
8. Provide appropriate communication to Molina Medicaid Solutions Provider Enrollment Unit with any additions or deletions to the linked Nurse Practitioner(s) or M.D.(s) listed on the PE 50 Form.
9. Indicate the SBHC classification below:
 - OPH-ASHI (Adolescent School Health Initiative) Funded (MUST submit with this application a certification letter from OPH-ASHP that SBHC meets certification requirements)
 - Other – OPH certified (MUST submit with this application a certification letter from OPH-ASHP that SBHC meets certification requirements)

I do hereby agree to adhere to all enrollment requirements/condition of Medicaid of Louisiana. I affirm that all statements I have made on this application and attachments are true and correct and that I will give services provided to those recipients receiving services through the SBHC program.

I further acknowledge that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

Signature _____ Date _____
Signature of Authorized Representative Date of Signature

Print Name of Authorized Representative _____

Louisiana Medicaid Link/Unlink and Working Relationship Form

PURPOSE

This form is used when an individual provider is requesting to be linked to a Professional Group or Entity. The form permits Linkage/Unlinkage for two separate professional groups. When linking to a group, the estimated number of hours is required. The form also serves as documentation that a working relationship exists between an individual and a professional group. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE ARE REQUIRED.**

Individual Provider Name:													
Individual Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week (required)													
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week (required)													
Contact Person for questions regarding this form:													
Contact Person Phone Number:		() -											

WORKING RELATIONSHIP AGREEMENT

I am a medical professional who has a written contractual agreement to see patients for the above named professional group(s). I have recorded the approximate number of hours to be worked at each group per week in the space(s) provided above. (I understand that upon request I must provide DHH a copy of the written contractual agreement.)

Print Individual Provider's Name

Individual Provider's Signature

Date

**MAIL Completed Forms To:
Molina Medicaid Solutions Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159**

KIDMED Certification Checklist & Attestation:

This document must be completed by all providers enrolling in the Louisiana Medicaid KIDMED Program and include a provider authorized signature on the last page of this certification attestation.

Provider Name: _____ **Provider # & site:** _____ (If known)

Clinic Physical Address: _____ **Date:** _____

Staff Completing This Checklist:

Initials: _____ Signature: _____ Print Name: _____

Initials: _____ Signature: _____ Print Name: _____

Initials: _____ Signature: _____ Print Name: _____

Initials: _____ Signature: _____ Print Name: _____

Section 1: Credentials

CLINICAL STAFF LICENSES (MD, RNP, PA, RN)
Name & title: _____ License # _____ Exp Date _____
Name & title: _____ License # _____ Exp Date _____
Name & title: _____ License # _____ Exp Date _____
Name & title: _____ License # _____ Exp Date _____
Name & title: _____ License # _____ Exp Date _____
Name & title: _____ License # _____ Exp Date _____
Name & title: _____ License # _____ Exp Date _____

NOTE: Ensure that all clinical staff (MD, RNP, PA, & RN) who will be providing KIDMED services are identified in the table to the left AND that their current & valid provider license information is provided.

CPR Certified Staff: Name _____ Exp date _____ Copy provided _____
 Name _____ Exp date _____ Copy provided _____
 Name _____ Exp date _____ Copy provided _____

CLIA certificate # _____ Exp date _____ Copy provided _____

- **Provider must submit copies of clinical licenses, CPR card(s), & CLIA certificate with this document.**
- **Provider must submit copies of license for MD, RNP, PA and/or RN with this document.**

Section 2: Office Structure/Safety

- 1) Site is handicapped accessible: _____(Init)
 - 2) Exit signs in place: _____ (Init)
 - 3) Fire extinguisher: _____ (Init) _____ (Date Inspected)
 - 4) Fire evacuation plan posted: _____(Init)
 - 5) Appropriate cleaning solution and disinfecting procedures: _____ (Init)
 - 6) Accessible sink with antimicrobial hand cleanser: _____ (Init)
-

Section 3: Equipment & Supplies

- 1) Personal Protective Equipment: Disposable gloves and aprons; goggles or face shields: _____ (Init)
- 2) Developmental Assessment Tool:
 - a) Assessment Tool Used: _____ (Init) (If Denver II is used, list names of certified staff below and submit copies of certificates: _____)
 - i) NOTE: Provider must currently have the selected Developmental Assessment Tool in their office and all staff utilizing tool must have documentation of appropriate training for the selected assessment tool. _____ (Init)
 - ii) Referral forms & referral process to EarlySteps Early Intervention Services: _____ (Init)
- 3) Blood Pressure Cuffs:
 - a) Infant: _____ (Init)
 - b) Child: _____ (Init)
 - c) Adult: _____ (Init)
- 4) Stethoscope(s): _____ (Init)
- 5) Weigh Scales:
 - a) Standing: _____ (Init)
 - i) Balance Log: _____ (Init) Calibration Date: _____ (Init)
 - b) Infant: _____
 - i) Balance Log: _____ (Init) Calibration Date: _____ (Init)
- 6) Height Measurement: _____ (Init)
- 7) Length Measurement: _____ (Init)
- 8) Head Circumference Measurement (e.g. disposable tape measures): _____ (Init)
- 9) Age appropriate growth grids: _____ (Init)
- 10) Examination tables: _____ (Init)
- 11) Patient gowns: _____ (Init)
- 12) Patient drapes: _____ (Init)
- 13) Vision Screening Equipment:
 - a) Visual Acuity (e.g. Snellen chart, Allen cards/occluder, Titmus, etc.) – list what visual acuity equipment utilized: _____ (Init)
 - i) If Titmus machine is utilized, please provide serial number: _____
 - b) Polychromatic Color Perception Plates (e.g. Ishihara, Stilling, Hardy-Rand-Ritter, etc.) – list what color perception method utilized: _____ (Init)
 - c) Penlight: _____ (Init)
- 14) Otoloscope with disposable or cleanable attachments: _____ (Init)

Section 3: Equipment & Supplies (continued)

15) Hearing Screening Equipment:

- a) Audioscope or Audiometer: Type: _____ (Init)
- b) Serial Number: _____ (Init)
- c) Last Calibration Date: _____ (Init)

16) Vaccines (KIDMED Providers MUST be enrolled in Vaccines for Children (VFC) Program)

- a) Enrolled in VFC: _____ (Init)
 - i) VFC Facility Name: _____ (Init)
 - ii) VFC PIN Number: _____ (Init)
- b) Standing Orders for vaccines: _____ (Init)
- c) Standing Orders for Anaphylaxis: _____ (Init)

17) Emergency Equipment and Medications:

- a) Epinephrine: _____ (Expiration Date) _____ (Init)
- b) Benadryl: _____ (Expiration Date) _____ (Init)
- c) Emergency Checklist documenting monthly review: _____ (Init)
- d) Suction equipment: _____ (Init)
- e) Oxygen & tubing: _____ (Init)
 - i) Age appropriate oxygen masks: _____ (Init)
 - ii) Age appropriate oxygen cannulas: _____ (Init)
 - iii) Ambu bags: _____ (Init)

18) Laboratory Equipment & Supplies:

- a) Laboratory appropriate sharps containers: _____ (Init)
- b) Appropriate blood drawing and disposal equipment: _____ (Init)
- c) Urine dip sticks for pH, protein, blood, glucose, leukocytes, and nitrite: _____ (Init)
 - i) Expiration Date: _____
- d) Containers for urine collection: _____ (Init)
- e) Blood lead testing collection tubes: _____ (Init)
- f) Neonatal metabolic screening materials: _____ (Init)
- g) Hemoglobin meter or centrifuge (or equivalent equipment) for iron deficiency anemia screening: _____ (Init)
 - i) Equipment Type: _____ Serial #: _____
 - ii) Control log: _____ (Init)
 - iii) Expiration date of strips/curvettes: _____ (Init)
- h) Blood Lead Testing:
 - i) Lead poisoning risk assessment questionnaire: _____ (Init)
 - ii) Lab used: _____ (Init)
 - iii) If Blood Lead Testing Equipment for in office testing is used, provide the name and serial number of the CLIA waived equipment: _____ (Equip Name) _____ (Serial #) _____ (Init)
 - (1) Lead Proficiency Log: _____ (Init)
 - (2) Lead Testing equipment control log: _____ (Init)
 - iv) Elevated Lead Reporting forms/protocol: _____ (Init)
- i) Metabolic/PKU Testing:
 - i) Lab used: _____ (Init)
 - ii) Lab forms: _____ (Init)

Section 4: KIDMED Provider Requirements

1. An appropriate screening appointment system must ensure that initial and periodic appointments are scheduled within the designated screening period.
2. An appropriate appointment follow-up system must ensure that there are follow-up activities on missed screening appointments. The provider must make and document two good-faith efforts to reschedule the appointment.
3. An appropriate referral appointment scheduling system must ensure that patients are referred to specialists for conditions found or suspected during the screening.
4. An appropriate referral follow-up system must ensure that services for patients referred for further diagnosis and/or treatment are initiated within 60 days of screening. The provider must make and document two good-faith efforts to reschedule any missed appointments.
5. An appropriate Women, Infants, Children (WIC) referral system must ensure that eligible women, infants, and children under the age of five years are referred for WIC services.
6. Staff performing KIDMED screenings on children under thirteen years of age must have appropriate pediatric training and documentation of training must be is available upon request.
7. At all times, at least one member of the medical staff on duty must be currently certified for CPR.
8. At all times, the office's CLIA Certificate of Registration or Waiver must be valid. Any changes/updates that are necessary must be reported to DHH, Health Standards-CLIA office.
9. Trained staff must take all medical history, and a licensed physician, advance practice registered nurse, registered nurse, or certified physician assistant must interpret it.
10. If the Denver II Developmental Assessment tool is utilized, staff trained and certified by a certified Denver II Trainer must conduct all Denver II Developmental Assessments.
11. A licensed physician, advance practice registered nurse, registered nurse, or certified physician assistant must conduct all unclothed physical exams or assessments.
12. A licensed physician, advance practice registered nurse, registered nurse, certified physician assistant, licensed practical nurse or trained medical staff, under the supervision of a licensed physician, must give all immunizations.
13. A licensed physician, advance practice registered nurse, registered nurse, certified physician assistant, licensed practical nurse, or licensed lab technician must perform all venipunctures for blood samples.
14. A licensed physician, advance practice registered nurse, registered nurse, certified physician assistant, health educator, or other medical staff trained in health education must provide all anticipatory guidance.
15. A licensed physician, advance practice registered nurse, registered nurse, or certified physician assistant must conduct all interpretive conferences.

- 16. A licensed physician, advance practice registered nurse, registered nurse, or certified physician assistant must conduct all objective vision screenings.
- 17. A licensed physician, advance practice registered nurse, registered nurse, or certified physician assistant must conduct all objective hearing screenings.

Section 5: Attestation and Signature

I certify that the above listed equipment, supplies and requirements are in place in this practice and the completed information is accurate. Furthermore, I understand that providing false or inaccurate information may result in termination from the CommunityCARE and KIDMED programs.

Provider Authorized Signature: _____ Date: _____

Please Print Name: _____

KIDMED Resource Sheet

KIDMED/CommunityCARE Enrollment Questions: www.la-kidmed.com or (225) 342-0327

Billing Questions & KM-3 Claim Forms: MOLINA MEDICAID SOLUTIONS (800) 473-2783 or (225) 924-5040 (www.lamedicaid.com)

Clinical Laboratory Improvement Amendments (CLIA) Waiver or Certificate:

- For CLIA information, call (225) 342-9324 or go to the CMS Website: <http://www.cms.hhs.gov/clia/>

Neonatal Screening Phenylketonuria (PKU) forms:

- For all inquires (including **blue edged forms**): (504) 219-4413(telephone) or (504) 219-4452 (FAX)
- Neonatal screening forms can also be obtained from the local health unit in each parish.
- Neonatal screening results: Voice Response System (866) 239-1644 or (225) 219-0042 (office)
- OPH Genetic Disease website: <http://www.dhh.louisiana.gov/offices/?ID=263>

- **Blood Lead collection equipment finger stick** call **Tamarac Medical** at (800) 842-7069
- For all lead inquires, call: (504) 219-4413.
- Voice Response System: (800) 242-3112
- Lead website: www.lead.dhh.louisiana.gov

Women, Infants, and Children (WIC) forms: Call the WIC office at (504) 361-6725.

- For more information, go to: www.dhh.louisiana.gov/offices/?ID=320

Vaccines for Children (VFC) & Louisiana Immunization Network for Kids Statewide (LINKS):

- Office number: (504) 838-5300 Fax (504) 838-5255. Website: www.dhh.louisiana.gov/offices/?ID=265
- KIDMED providers are to administer childhood and adolescent vaccines as identified on the current 'Recommended Immunization Schedules' published by CDC/Advisory Committee on Immunization Practices (ACIP) www.cdc.gov/vaccines and the American Academy of Pediatrics (AAP) www.aap.org,
- **Vaccines Information Statements (VIS)** are available to download from the CDC website at www.cdc.gov/vaccines under 'Publications'.

CPR Certification Resource: American Heart Association:

- For information on CPR and available classes call (877) AHA-4CPR/(242-4277) or go to www.americanheart.org

Developmental Assessment Tools (Developmental Screening for age birth thru 6 years):

The following developmental screening instruments are approved for use for the KIDMED developmental screenings. Providers have the choice to use one or more of these instruments to meet Medicaid/KIDMED screening requirements.

- Ages & Stages Questionnaires (ASQ): www.com/stbrookespublishingore/childdevelopment.htm or telephone (800) 638-3775.
- Brigance Screens: www.curriculumassociates.com or telephone (800) 225-0248.
- Child Development Chart (CDC): www.childdevrev.com.
- Denver II: www.denverii.com or telephone (800) 419-4729.
- Parent's Evaluation of Developmental Status (PEDS): www.pedstest.com or telephone (877) 296-9972.
- Prescreening Developmental Questionnaire (PDQ II): www.denverii.com or telephone (800) 419-4729.

Growth Charts:

- Available for download from CDC the website: www.cdc.gov/growthcharts (choose Clinical Growth Charts).