ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

CommunityCARE Enrollment Packet

(Enrollment packet is subject to change without notice)

To Whom It May Concern:

Thank you for your interest in the Louisiana CommunityCARE Program. CommunityCARE is a comprehensive health care system based on primary care case management. Medicaid eligibles are assigned to a primary care physician (PCP). The PCP has total responsibility for coordinating enrollees' health care including education, preventive and acute care, and referrals to specialists or other health services when necessary in accordance with Medicaid, CommunityCARE & KIDMED policy. The goals of the CommunityCARE program are to ensure adequate access to quality care, to provide continuity of care, and to prevent, as well as reduce, inappropriate utilization of health care services.

Enclosed for your review are:

- Checklist of Required forms
- PE-50 CommunityCARE Provider Supplement Agreement
- CommunityCARE/KIDMED Services Agreement
- PE-50 KIDMED Provider Enrollment Supplement Agreement

Please return completed enrollment forms to:

Louisiana Department of Health and Hospitals
Attention: CommunityCARE
P.O. Box 91030
Baton Rouge, LA 70821-9030

Mailing of completed forms to any other address will delay your enrollment.

For questions concerning certification issues, you may contact CommunityCARE at 225-342-0327.

General questions regarding CommunityCARE policies and procedure may be directed to the Molina Provider Relations Unit at 800/473-2783 or 225/924-5040.

Sincerely,

Provider Enrollment Unit

CC PE-50 Supplement
Revised 05/09

CommunityCARE
CHECKLIST OF FORMS TO BE SUBMITTED

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). DO NOT SUBMIT COPIES OF THE ATTACHED FORMS.

The following checklist shows all documents that must be submitted in order to enroll in the Louisiana Medicaid Program as a CommunityCARE provider.

Completed	Document Name
☐ **	1. CommunityCARE PE-50 Provider Supplement Agreement* (six pages) **(Required for all providers – All items must be completed.)**
☐ **	2. CommunityCARE/KIDMED Services Agreement* (two pages) **(This form must be completed if you are providing acute care to children under age 21 and will be subcontracting out KIDMED services to another provider.)**
☐ **	3. PE-50- KIDMED Provider Enrollment Supplement Agreement*(three pages) **(Must be completed if you are providing care to children under age 21 and you intend to become a certified KIDMED provider and provide KIDMED services at this practice location.)**
☐ **	4. Completed Retainer Agreement Medical Director (2 pages).
☐ **	5. KIDMED Certification Checklist and Attestation (5 pages).

**** If you are not currently an active Louisiana Medicaid provider, additional paperwork is required.***

*****Forms are included here.***

Please submit all completed forms to:
Louisiana Department of Health and Hospitals
Attention: CommunityCARE
P.O. Box 91030
Baton Rouge, LA 70821-9030

Inquiries specifically related to the certification process and completion of the CommunityCARE and KIDMED enrollment forms should be directed to CommunityCARE at 225-342-0327.

COMMUNITYCARE PE-50 PROVIDER SUPPLEMENT AGREEMENT

Please review the instructions and complete this form in its entirety. Incorrect or incomplete forms will be returned to you for correction or completion.

PRACTICE INFORMATION

Provider Name ______________________ Provider # ______________________

Physical Street Address ______________________ Suite ______________________

City ____________ Parish ____________ State ________ Zip Code ________

Office Telephone* ( ) ______________________ Office Fax Number ( ) ______________________

After Hours Telephone ( ) ______________________ Email ______________________

Pay-To Address ______________________

City ____________ Parish ____________ State ____ Zip Code ________

Tax ID ______________________ Social Security Number ______________________

***This phone number will be the number that is available on the REVS/MEVS information systems and will be given to enrollees to be used for scheduling appointments.**

Practice Restrictions:

Check One

- ☐ CURRENT PATIENTS ONLY
- ☐ CHILDREN ONLY (age 0-20)
- ☐ Adults and Children (age 0-64)
- ☐ Adults Only (age 21 & up)
- ☐ Other: (Please Explain) ______________________

Refer to the CommunityCARE Handbook for details regarding practice restriction options.

Languages spoken by staff in this practice (check all that apply):

☐ Sign Language ☐ English ☐ Spanish ☐ Vietnamese ☐ Other____________

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							
Lunch	To	To	To	To	To	To	To

Provider Name: ______________________________ **Provider #:** ____________________

List all Physicians, Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants in this practice. You may make additional copies of this form if more space is needed.

MEDICAID PROVIDER #	PROVIDER NAME	DAYS/HOURS PER WEEK (This Office)	HOSPITAL ADMITTING PRIVLEGES / OR ALTERNATIVE ARRANGEMENT ** (Specify)
			Facility:
			Alternative:
			Facility:
			Alternative:
			Facility:
			Alternative:
			Facility:
			Alternative:
			Facility:
			Alternative:
			Facility:
			Alternative:

All changes in professional medical staff must be reported to CommunityCARE.

** Refer to page 4 of 6, item #7 for details regarding admitting privilege requirements

Provider Name:______________________________Provider Number: ______________

The above named provider does hereby elect to participate in the Louisiana Medicaid CommunityCARE Program. This Agreement, made by and between the Department of Health and Hospitals, Bureau of Health Services Financing and the above Medicaid enrolled provider sets forth the terms of participation in the CommunityCARE Primary Care Case Management Program. This agreement is an amendment to the original CommunityCARE Agreement, to incorporate Federal regulations in accordance with the Balanced Budget Act Amendments for Medicaid Managed Care found in 42 CFR Parts 400, 430, 431, 434, 435, 438,440,and 447.The parties, intending to be legally bound, agree as follows:

1. The provider agrees to adhere to all general Medicaid enrollment conditions, as well as Federal & State Medicaid regulations and State Plan Standards, and to serve as the enrollees' PCP in accordance with CommunityCARE policies and procedures set forth in the CommunityCARE Handbook.

2. The provider agrees not to refuse an assignment or disenroll a participant, or use any policy or practice, or otherwise discriminate against a participant solely on the basis of age, sex, race, sexual orientation, national origin, health status or need for health care services except when that illness or condition can be better treated by another provider type. The provider further agrees to accept enrollees in the order in which they are assigned, up to the limits set in this agreement.

3. The provider understands that enrollees may request reassignment without cause during the first 90 days following enrollment with a PCP, or at anytime for cause, as detailed in the CommunityCARE Handbook. The provider further understands that enrollees have an opportunity to change PCPs, without cause, during a 60 days open enrollment period each year.

4. The PCP understands that he/she may not request disenrollment of a enrollee because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PCP's ability to furnish services to either this particular enrollee or other enrollees.) The State will monitor PCP requests for disenrollment of enrollees via a monthly report of disenrollment reasons.

5. The PCP agrees to provide written/electronic referral authorizations, in accordance with CommunityCARE policy, including but not limited to the following:

   a) The provider agrees to authorize certain necessary medical care obtained from other providers by issuing **"administrative or transitional referral authorizations"**, as detailed in the CommuityCARE Handbook.

   b) The PCP understands that prior authorization is not required for emergency care and agrees to approve or deny requests for post-authorizations for emergency services based upon whether the **presenting symptoms** meet the prudent layperson standard.

6. The PCP understands that enrollees have freedom of choice when choosing a provider for family planning services or other medically necessary specialty care.
7. The PCP agrees to maintain hospital admitting privileges sufficient to meet the needs of all enrollees linked to him/her, or to provide a detailed explanation of arrangements for necessary inpatient care. **NOTE:** If a PCP provides primary care to all ages but only has admitting privileges for adults, or only has privileges at a hospital that does not accommodate pediatric patients, a detailed explanation of arrangements for pediatric admissions must be attached. If a PCP provides primary care for all ages, but only has admitting privileges for patients under the age of 21, an explanation of arrangements for adult admissions is required.
8. The PCP agrees to provide, or have formal arrangements with a certified KIDMED (EPSDT) provider, to provide KIDMED services to all CommunityCARE enrollees under the age of 21 who are linked to him/her. **Check the appropriate box below.**

☐ I will provide KIDMED services to all enrollees, under age 21, who are linked to me.

☐ I will subcontract all or a portion of KIDMED services. **NOTE: A CommunityCARE KIDMED Services Agreement must be completed if any portion of the KIDMED services are subcontracted.**

9. The PCP agrees to cooperate and participate in quality assessment activities and quality improvement projects initiated by the State as required for managed care programs. These activities may include analyzing utilization reports provided to the PCP by the State, on-site monitoring visits, data collection efforts, and performance improvement interventions.

10. The PCP understands and agrees that marketing materials, as defined in the CommunityCARE Provider Handbook, must be approved by the State **prior** to distribution. The PCP understands that in the event he/she fails to comply with these provisions, appropriate sanctions, up to and including termination from participation as a CommunityCARE PCP (or provider within a group PCP), will be applied by BHSF.

11. The provider understands that a $3.00 per eligible enrollee, per month management fee, in addition to the regular fee for service reimbursement, will be paid regardless of whether or not the enrollee received services that month. Refer to the CommunityCARE Handbook for details.

12. In accordance with Federal regulations CommunityCARE providers must provide 24 hour-a-day, 7 day-a-week arrangements for access to appropriate care: arrangements to inform patients when to call the office for appointments; arrangements to inform patients how to access care/medical advice when the office is closed; arrangements for hospital admissions (routine/emergent). The PCP agrees to provide such coverage in accordance with the CommunityCARE Handbook. The intent of the 24/7 access to medical advice and triage is intended to reduce fragmented, episodic care and unnecessary utilization of hospital emergency rooms for non-emergent care. (See PCP Statement of Coverage on page 5 of 6).

13. Participation in the CommunityCARE Program, and choices made by enrollees, are based on the PCP's practice and qualifications at the time of certification. The provider agrees to notify the CommunityCARE Program, in writing, **at least 60 days prior** to any changes within their practice, in accordance with the CommunityCARE Handbook.

14. **The provider agrees to give the Bureau a 60-day written notice before terminating the CommunityCARE agreement so that enrollees may be linked to another PCP to avoid any interruption in the enrollee's health care.**

PCP Statement of Coverage

The undersigned PCP certifies that:

a) He/she has a formal written/verbal agreement with the Medicaid provider(s) listed below to provide back-up coverage when the PCP is not available.

b) The provider(s) listed have been provided with the PCP's Referral/Authorization Number to use when billing Medicaid for services provided on behalf of the PCP as the designated backup provider.

c) The providers listed below have been made aware of the scope of their responsibilities in accordance with the CommunityCARE Handbook.

In the space below, provide a **detailed** explanation of the regular and after-hours/weekend coverage arrangements in effect for this practice. Details of backup coverage must include **who** the backup coverage is with (clinic/physician name, address, telephone number, answering service, call group, etc), **what** days/hours this agreement is in effect and a step-by-step account **how** an enrollee linked to you obtains care when you are not available.

REGULAR HOURS COVERAGE:

____

____

____

____

____

____

AFTER-HOURS/WEEKEND COVERAGE:

I certify that I have read the above conditions set forth in this agreement, and that the information provided is accurate. I understand that failure to comply with any of the provisions in this agreement may result in sanctions, up to and including termination from participation as a CommunityCARE PCP (or provider within a group PCP). I further understand that the Bureau of Health Services Financing may terminate this agreement immediately upon written notice to the provider when such is considered necessary to ensure the continuance of necessary and appropriate service to Medicaid recipients.

CommunityCARE Provider (Please Print) Provider #

CommunityCARE Provider Authorized Signature Date

FOR DHH USE ONLY:

Medicaid Director or Designee Date

CommunityCARE/KIDMED Services Agreement

This agreement, made between ______________________________________, the CommunityCARE Provider, and ____, a currently certified KIDMED Provider, shall be effective beginning _____________________________ and thereafter unless either party terminates this agreement by giving written notice to the other party.

The KIDMED Provider agrees to provide KIDMED services for the CommunityCARE Provider for all CommunityCARE recipients who are within the age group(s) checked below and in accordance with the terms and provision set forth in this agreement and the KIDMED Provider Manual.

	Age Group	Any modification to an age group should be explained in this column
	0 - 5 years	
	6 - 13 years	
	14 - 20 years	

The CommunityCARE PCP hereby authorizes the KIDMED Provider to use the Referral Authorization Number, ____________________________, for billing services covered by this agreement for the time period specified by this agreement.

The KIDMED Provider agrees to:

1. Follow KIDMED policy and procedures.
2. Follow the Bureau of Health Services Financing's approved KIDMED periodicity schedule.
3. Accept the RS-0-07 Report as the referral document from the CommunityCARE provider to schedule and complete the medical, vision and hearing screenings and immunizations for CommunityCARE recipients covered by this agreement. The PCP's referral authorization number must be on the KIDMED claim form in Item 9, "Refer Provider No", or in Block 17A of the HCFA 1500. If the authorization number is not in the designated field on the claim form, the claim will be denied. DO NOT ATTACH THE REFERRAL TO THE CLAIM. Unauthorized use of a CommunityCARE provider's authorization number for billing purposes shall result in recovery by the Medicaid Program of all reimbursements from the unauthorized billing physician/agency. Submission of a fraudulent claim is punishable by fine and/or imprisonment.
4. At the end of each month, return the RS-0-07 Report to the PCP indicating the CommunityCARE recipients who failed to keep appointments.
5. Notify the PCP of a suspected condition.

6. Refer children needing immediate medical care to the PCP for treatment.

7. In cases of failure of any of the approved screening tools, refer the child to his/her PCP and notify Early Steps (part C).

8. Complete forms necessary for referral to "Children's Special Health Services" and forward to PCP. Services provided by the "Special Children's Health Service Clinics" (formerly Handicapped Children's Services) operated by the Office of Public Health require a referral from the PCP. The recipient has the freedom of choice to choose any provider who accepts Medicaid patients and is not required to accept OPH as the provider.
   If the OPH Health Unit is doing KIDMED screening for a PCP and identifies a problem, they are to refer that child to the PCP with the necessary forms completed for referral to the Special Children's Service Clinic. It is the PCP's responsibility to see that the child is referred for follow up treatment.

9. Complete the WIC-17 Infant/Child Referral for certification and recertification. WIC information is to be forwarded to the PCP for inclusion in the recipient's medical record.

10. Forward medical records to the PCP when screenings are completed or immunizations are given or as specified below:

The Primary Care Provider agrees to:

1. Send the RS-0-07 monthly report WITHIN 5 WORKING DAYS OF RECEIPT to the KIDMED Provider indicating the recipients to be screened. Only the information pertaining to recipients that the KIDMED provider is responsible for should be legible. All other recipient information must be blacked out.
2. Assure that all CommunityCARE children linked to them are screened within periodicity.
3. Follow up in writing with recipients who have failed screening appointments and document the follow up in the recipient's medical record.
4. Assure that suspected conditions and "special needs" children are referred to the appropriate clinics or specialists.
5. Maintain screening information as part of recipients' medical records.

This agreement is a condition of CommunityCARE provider participation. Any changes to this agreement require a written notice at least 60 days prior to the proposed change, to both the other party and the CommunityCARE Program. An approved change requires a new agreement to be signed and a copy sent to the CommunityCARE Program. This agreement may be terminated by either party within sixty (60) days with written notice to the other party and the CommunityCARE Program.

KIDMED Provider	Date
CommunityCARE Provider	Date
CommunityCARE Program Manager Bureau of Health Services Financing	Date

PE-50 KIDMED PROVIDER ENROLLMENT SUPPLEMENT AGREEMENT

In order to facilitate your enrollment as a KIDMED provider in Louisiana Medicaid, you must provide the information that is requested below. Please print.

Name of Provider: ____

( ) Currently enrolled as Medicaid provider
If yes, Medicaid provider # _____________
( ) Not enrolled in Medicaid, PE-50 attached

Pay to (Mailing)
Address: ____

Telephone: _______________________________Fax #: ___________________________IRS#: _____________________

Physical Address of KIDMED site(s):

Street Address	City	State/Zip Code	Area Code/Telephone

Check the KIDMED service(s) you wish to provide:

_____Medical Screening _____Vision _____Hearing _____Diagnosis & Treatment

Check the category of medical screening (Scr) and/or diagnosis and treatment (D&T) under which you qualify:

Scr	D&T	Scr	D&T	Scr	D&T
__	___Public Health Clinic	__	___Rural Health Clinic	__	___Physician Group
__	___Federally Qualified	__	___Local Education Agency	__	___Nurse Practitioner
__	___Health Center (FQHC)	__	___Individual Physician	__	___KIDMED Clinic *
__	___FQHC & OPH certified School Based Health Center (SBHC)			__	___SBHC

*A KIDMED Clinic may not provide diagnosis and treatment services.

List the specific days and hours the office will be open: ____

The Agreement, made by and between Louisiana Medicaid and ____

_________________________________(provider), sets forth the terms of participation in KIDMED medical, vision, hearing screening, and diagnosis and treatment services. The parties, intending to be legally bound, agree as follows:

1. The provider agrees to adhere to all general enrollment conditions of the Louisiana Medicaid Program.

2. The provider agrees to comply with all applicable KIDMED requirements for physician affiliation/medical direction, staffing, equipment, services, timeliness standards, and reasonable standards of medical and other health professional practices set forth in the KIDMED Provider Manual.

3. The provider agrees to maintain sufficient qualified and trained staff, facilities, equipment, and supplies to provide the agreed-upon services.

4. The provider agrees to notify KIDMED within 10 days whenever he/she no longer meets all enrollment criteria or is unable to provide the required services as set forth in the KIDMED Provider Manual.

5. The provider agrees to ensure that recipients are allowed to choose providers freely, except as provided under a Medicaid-approved managed care program.

PE-50 KIDMED PROVIDER ENROLLMENT SUPPLEMENT AGREEMENT

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 statue.

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

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

____

WITNESS DATE FACILITY DATE

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 _______

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) Otoscope 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 (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).