



**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 Gainwell 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 Retainer Agreement Medical Director (2 pages).
<input type="checkbox"/> **	10. Completed Supplemental Provider Enrollment Agreement for SBHC providers form (1 page).
<input type="checkbox"/>	<p>11. 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: 20px;">A. OPH-ASHI (Adolescent School Health Program funded) Certificate</p> <p style="margin-left: 40px;">or</p> <p style="margin-left: 20px;">B. OPH Acceptance Letter</p>
<input type="checkbox"/> **	12. 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"/> **	13. 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"/>	14. 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:
Gainwell 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.**

RETAINER AGREEMENT MEDICAL DIRECTOR

This agreement is entered into on this _____ day of _____ between _____, M.D., hereinafter referred to as MEDICAL DIRECTOR, of _____ SBHC, 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 Individual Provider(s) linking to a SBHC must be individually enrolled in Louisiana Medicaid.
3. Coordinate and cooperate with the child's medical home (PCP) including submission of any relevant medical visit information to the PCP.
4. Bill all Medicaid services provided onsite under the SBHC Medicaid provider number.
5. Assure that a Registered Nurse only provides services under the direction of a Nurse Practitioner or Medical Doctor.
6. Agree to provide services under one of the specialty types listed on the PE 50 Form.
7. Provide appropriate communication to Gainwell Provider Enrollment Unit with any additions or deletions to the linked Nurse Practitioner(s) or M.D.(s) listed on the PE 50 Form.
8. 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 _____

Please Print Name of School-Based Health Center: _____

List all Louisiana Medicaid Provider Name/Number(s) of individuals that are being linked to the School-Based Health Center with this application:

Provider Name	Provider Number

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)					
LINK	Effective Date:					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)					
LINK	Effective Date:					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:
Gainwell Provider Enrollment Unit PO Box 80159
Baton Rouge, LA 70898-0159**