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

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

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

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

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

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

☐ **Add** the practitioners listed as qualified providers of services to students with IEPs. All appropriate current licenses and certificates are attached. *Remember to include licensure/verification when adding practitioners

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

Superintendent or Medicaid Liaison (signature) Date

***If the district is adding Health Aides, please ensure they are listed on Page 2 of this amendment form, which must be signed by the supervising nurse.**

Medicaid Health Aide List

PRACTITIONER LAST NAME	PRACTITIONER FIRST NAME	MI	TITLE

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.

*Required

*Supervising Nurse (signature) *Date