



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

Dear Applicant:

Thank you for your interest in enrolling in the New York State Medicaid Program.

Participation in the New York State Medicaid program is an important undertaking. Therefore, we want you to be aware of the following factors concerning your potential enrollment as a provider.

- **If your application is approved, the effective date of your enrollment will be specified by the Department.**
- **You will be at financial risk if you render service to Medicaid patients before successfully completing the enrollment process. Payment will not be made for any claims submitted for services, care or supplies furnished before the enrollment date authorized by the Department.**
- **Receipt of provider ID # does not negate the need for a prior approval number for individual cases. Please review the prior approval information section of the Private Duty Nursing Manual before starting any cases. You will still be at financial risk if you begin a private duty nursing case before obtaining the appropriate prior approval number.**
- **Your signature on the application acknowledges that you have received, read and will comply with the policies and regulations of the Medicaid Program.**

All business matters relating to your practice are your responsibility. You are self-employed and **are not** considered employed by the New York State Department of Health.

Enrollment for fee-for-service is only appropriate for home care providers. If you are a nurse applying for Medicaid enrollment and are employed in a physician's office or hospital you are not eligible for Medicaid reimbursement.

When you are enrolled in the program, you will receive a letter informing you of your acceptance and the effective date of your enrollment. You will also receive a package containing claim forms and instructions on how to obtain the appropriate Provider Manual which is available online at www.eMedNY.org. If you do not have internet access you can obtain the appropriate provider manual by calling the eMedNY Call Center at (800) 343-9000. The Provider Manual contains New York State Medicaid policy, a list of information sources, and billing instructions. Click on Provider Manuals and scroll down and choose the appropriate manual. The Medicaid Update may be accessed at www.eMedNY.org, click on Information, then DOH Medicaid Update Website.

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including, but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.

In addition, pursuant to 42 CFR §455.105 by enrolling in the Medicaid program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department of the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5-year period ending on the date of the request.

New York State Medicaid Regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

If you have any questions, please contact the eMedNY Call Center at (800) 343-9000.

Sincerely,

Fee for Service Provider Enrollment Bureau
Office of Health Insurance Programs

Enclosure

LPN/RN

EMEDNY-413101 (08/09)

**MEDICAID PROVIDER ENROLLMENT
NURSING FORM CHECKLIST**

THE FOLLOWING INFORMATION MUST BE PROVIDED TO PROCESS YOUR ENROLLMENT APPLICATION.

FAILURE TO SUBMIT REQUIRED INFORMATION MAY RESULT IN YOUR APPLICATION BEING RETURNED TO YOU AND WILL DELAY THE ENROLLMENT PROCESS.

REQUIRED FIELDS TO BE COMPLETED ON THE ENROLLMENT FORM

TYPE OF APPLICATION*

PAY TO ADDRESS **(This cannot be a beneficiary's address. A beneficiary's address would be a serious HIPAA violation which could result in the provider not being able to enroll in the Medicaid Program.)**

NATIONAL PROVIDER IDENTIFIER (NPI)

SERVICE ADDRESS **(This cannot be a beneficiary's address. A beneficiary's address would be a serious HIPAA violation which could result in the provider not being able to enroll in the Medicaid Program.)**

SOCIAL SECURITY NUMBER

ALL YES/NO QUESTIONS MUST BE ANSWERED **

CORRESPONDENCE ADDRESS **(This cannot be a beneficiary's address. A beneficiary's address would be a serious HIPAA violation which could result in the provider not being able to enroll in the Medicaid Program.)**

NURSE ORIGINAL SIGNATURE

*IF REINSTATEMENT IS CHECKED PLEASE SEE REQUIRED DOCUMENTATION ON PAGE 2 OF 2 OF THIS CHECK LIST.

**IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE PRIOR CONDUCT QUESTIONNAIRE AVAILABLE AT WWW.EMEDNY.ORG. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES.

REQUIRED DOCUMENTATION TO BE SUBMITTED

A NEW YORK STATE NURSE MUST SUBMIT A COPY OF THEIR NYS EDUCATION DEPARTMENT LICENSE/REGISTRATION RENEWAL CERTIFICATE

AN OUT OF STATE NURSE MUST SUBMIT A COPY FROM THEIR STATE LICENSING AGENCY

DISCLOSURE OF OWNERSHIP AND CONTROL – INDIVIDUAL FORM

IF YOU ARE REPORTING A FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN); SUBMIT A COPY OF THE DEPARTMENT OF TREASURY, INTERNAL REVENUE SERVICE LETTER OF ASSIGNMENT VERIFYING YOUR FEIN

IF YOU ARE REQUESTING RATE ENHANCEMENT FOR CARE OF MEDICALLY FRAGILE CHILDREN YOU MUST COMPLETE THE NEW YORK STATE MEDICAID PROGRAM NON-INSTITUTIONAL PEDIATRIC CONTINUOUS PRIVATE DUTY NURSING SERVICES CERTIFICATION OF NURSE TRAINING AND EXPERIENCE FORM INCLUDED IN THIS PACKAGE

REINSTATEMENTS

AN APPLICATION IS CONSIDERED TO BE A REINSTATEMENT IF THE APPLICATION WAS PREVIOUSLY EXCLUDED/TERMINATED FROM THE MEDICAID PROGRAM AS A RESULT OF COMMITTING AN UNACCEPTABLE PRACTICE, DISCIPLINE ACTION TAKEN AGAINST THEIR LICENSE, INDICTMENT, CONVICTION OR MEDICARE EXCLUSION.

IF YES ANSWERED TO ANY OF THE FOUR QUESTIONS, YOU MUST COMPLETE THE PRIOR CONDUCT QUESTIONNAIRE AVAILABLE AT WWW.EMEDNY.ORG. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION AND/OR DETAILS EXPLAINING THE CIRCUMSTANCES. IF YOU ANSWER YES TO THE FIRST OF THE YES/NO QUESTIONS BECAUSE YOU WERE EXCLUDED, TERMINATED, SANCTIONED, OR RESTRICTED BY AN AGREEMENT FROM ANY MEDICAID PROGRAM AND/OR MEDICARE PROGRAM YOU MAY BE REQUESTED TO SUPPLY INFORMATION AND/OR DOCUMENTATION DETAILING ALL CORRECTIVE STEPS YOU HAVE TAKEN TO DEMONSTRATE THE VIOLATIONS THAT LED TO YOUR EXCLUSION/TERMINATION WILL NOT BE REPEATED.

EXAMPLES:

- RE-EDUCATION COURSES;
- ATTESTATIONS FROM THIRD PARTY PAYERS;
- REPORTS FROM QUALITY ASSURANCE COMMITTEES REGARDING REVIEW OF RECORDS;
- MEDICARE REINSTATEMENT

PLEASE NOTE:

IF AN APPLICANT IS DENIED REINSTATEMENT, THE APPLICANT CANNOT RE-APPLY FOR REINSTATEMENT FOR TWO (2) YEARS FROM THE DATE OF THE DENIAL.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE MEDICAID PROVIDER ENROLLMENT APPLICATION

GENERAL INSTRUCTIONS

- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- Forms containing white out will be rejected.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not use staples.
- When including attachments less than 8 ½ “ x 11” in size, affix the attachment (using transparent single-sided tape) to an 8 ½” x 11” sheet of paper. When required attachments are greater than 8 ½ “ x 11” in size, make a reduced copy of the attachment using an 8 ½ “ x 11” sheet of paper.
- Double-sided forms will be rejected.

MEDICAID PROVIDER LPN/RN NURSING ENROLLMENT FORM INSTRUCTIONS

PROVIDER NUMBER:	Leave blank.
CATEGORY OF SERVICE:	Check the categories that apply. If dual licensed you are eligible for enrollment in both categories. Reimbursement is category specific and is based on prior approval.
APPLICATION TYPE:	This field must be completed. (See Required Documentation on page 2 of the checklist.)
APPLICANT NAME:	Enter the provider name exactly as it appears on your License; that is last name, first name .
DOING BUSINESS AS:	If applicable.
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter your NPI.
FEDERAL EMPLOYER ID NUMBER:	If the Department of Treasury, Internal Revenue Service letter is issued to you, please attach a copy. The Federal Employer Identification Number (FEIN) can only be put on your file if the government issued tax certificate is issued in your name. It cannot be put on the file if the FEIN is issued in a company's or group's name.
SOCIAL SECURITY NUMBER:	This is a mandatory field.

CORRESPONDENCE ADDRESS: Enter the address where all correspondence and claim forms will be sent. A street address is required to accommodate shipment of bulk material. **This cannot be a beneficiary's address. A beneficiary's address would be a serious HIPAA violation which could result in the provider not being able to enroll in the Medicaid Program.**

Attention Line: Use this only if the name or person who will receive the mail is different or for an apartment/suite number or building location.

Street: Cannot be a P.O. Box unless accompanied by an actual street address.

PAY TO ADDRESS: If you request that your checks be sent to an address other than the correspondence address, complete this section. This may be a P.O. Box. If you want your Medicaid checks to be sent to your correspondence address, write "SAME". **This cannot be a beneficiary's address. A beneficiary's address would be a serious HIPAA violation which could result in the provider not being able to enroll in the Medicaid Program.**

SERVICE ADDRESS: **ENTER YOUR HOME ADDRESS. This cannot be a beneficiary's address. A beneficiary's address would be a serious HIPAA violation which could result in the provider not being able to enroll in the Medicaid Program.**

CORPORATE ADDRESS INFORMATION Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid Services enrolled under other NPI(s). **NOTE:** Annual Tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay-To Address will be duplicated here.

YES/NO QUESTIONS: It is **mandatory** that all four (4) questions be answered. If yes answered to any of the four questions, you must complete the Prior Conduct Questionnaire available at www.eMedNY.org. You are required to provide documentation and/or details explaining the circumstances.

LICENSING INFORMATION: Enter your license number. If requesting dual categories of service, **attach copies of both current license/registration renewal certificates.**

EMAIL ADDRESS: Enter your email address is applicable.

SIGNATURE OF PROVIDER: Providers must **personally sign** and **date** the enrollment form. **Signature stamps, photocopies, etc. are not acceptable.**

PERSONAL PRIVACY LAW: The State's Personal Privacy Protection Law requires us to inform every person from whom we request the personal information why we are requesting the information and how we will use it.

The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities.

This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider.

The information will be maintained by:

New York State Department of Health
Office of Health Insurance Programs
Division of Provider Relations and Utilization
Management
Fee for Service Provider Enrollment Bureau
150 Broadway, Suite 6E
Albany, NY 12204

NURSING
CATEGORY OF SERVICE:
 0521 LICENSED PRACTICAL NURSE
 0522 REGISTERED NURSE

MEDICAID PROVIDER ENROLLMENT

MAIL TO: Computer Sciences Corporation
P.O. Box 4603
Rensselaer, NY 12144

PROVIDER NUMBER	<input type="text" value="(LEAVE BLANK)"/>	APPLICATION TYPE <input type="checkbox"/> New Enrollment/Reactivation <input type="checkbox"/> Reinstatement (See definition on pg 2 of checklist)
APPLICANT NAME	<input type="text" value="NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION"/>	
NATIONAL PROVIDER IDENTIFIER (NPI)	<input type="text" value="YOUR D/B/A NAME OR ANY OTHER NAME THAT THE COMPANY IS KNOWN BY"/>	FEDERAL EMPLOYER ID NUMBER <input type="text"/>
		SOCIAL SECURITY NUMBER (REQUIRED) <input type="text"/>

CORRESPONDENCE ADDRESS (Claim forms and mail). THIS CANNOT BE A CLIENT'S ADDRESS. A CLIENT'S ADDRESS WOULD BE IN SERIOUS HIPAA VIOLATION WHICH COULD RESULT IN THE PROVIDER NOT BEING ABLE TO ENROLL INTO THE MEDICAID PROGRAM.

ATTENTION

STREET - LINE 1

- LINE 2

CITY

STATE **COUNTY** **TELEPHONE** **EXT.**

PAY TO ADDRESS (Checks and Remittance Statements). THIS CANNOT BE A CLIENT'S ADDRESS. A CLIENT'S ADDRESS WOULD BE IN SERIOUS HIPAA VIOLATION WHICH COULD RESULT IN THE PROVIDER NOT BEING ABLE TO ENROLL INTO THE MEDICAID PROGRAM.

STREET - LINE 1

- LINE 2

CITY

STATE **COUNTY** **TELEPHONE** **EXT.**

SERVICE ADDRESS INFORMATION. THIS CANNOT BE A CLIENT'S ADDRESS. A CLIENT'S ADDRESS WOULD BE IN SERIOUS HIPAA VIOLATION WHICH COULD RESULT IN THE PROVIDER NOT BEING ABLE TO ENROLL INTO THE MEDICAID PROGRAM.

ATTENTION

STREET - LINE 1

- LINE 2

CITY

STATE **COUNTY** **TELEPHONE** **EXT.**

CORPORATE ADDRESS INFORMATION - <input type="text" value="ENTER THE NAME EXACTLY AS IT APPEARS ON THE FEIN DOCUMENT"/> ATTENTION LINE (TITLE OR DEPARTMENT NAME ONLY - EXAMPLE "CFO" OR "ACCOUNTING OFFICE") <input type="text"/> STREET ADDRESS - LINE 1 <input type="text"/> STREET ADDRESS - LINE 2 <input type="text"/> CITY - DO NOT USE ABBREVIATIONS <input type="text"/> COUNTY <input type="text"/> STATE <input type="text" value="ZIP CODE"/> <input type="text" value="DO NOT USE ABBREVIATIONS"/> TELEPHONE <input type="text" value="()"/> <input type="text" value="-"/> EXT. <input type="text"/>	LICENSING INFORMATION - ATTACH COPY LPN <input type="text"/> RN <input type="text"/> AGENCY CODE <input type="checkbox"/> NYS (03) <input type="checkbox"/> OUT-OF-STATE (99)
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YES NO QUESTIONS

Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?

Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?

Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?

Is there currently pending any proceedings that could result in the above stated sanctions?

I swear that the information that I have provided is true and accurate to the best of my knowledge.	EMAIL ADDRESS	<input type="text"/>
PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)	DATE SIGNED	PREPARER NAME & TITLE (PRINT) TELEPHONE #

DISCLOSURE OF OWNERSHIP AND CONTROL

INDIVIDUAL

As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.

In addition, pursuant to 42 CFR §455.105, by enrolling in the Medicaid Program, you are entering into an agreement with the NYS Department of Health by which you agree to and may be requested to provide the following information within 35 days upon request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request; and
2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

NOTE: The following questions do NOT only pertain to this provider application but include any and all past activity.

Respond to these questions on behalf of yourself and any individuals or organizations having a direct or indirect ownership or control interest of 5% or more, and any partners, directors, officers, agents or managing employees of the named provider completing this form.

1. Have you or an entity in which you had an ownership interest over 5% ever been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by the Medicaid Program in New York or any other state of the United States, Medicare, or any other governmental or private medical insurance program?
 Yes No
2. Have you ever been convicted of a crime relating to the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals?
 Yes No
3. Has your business or professional license or certification or the license of an entity in which you had an ownership interest over 5% ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any state?
 Yes No
4. Is there currently pending any proceedings that could result in the above stated sanctions?
 Yes No
5. Do you or your spouse, parent, child, or sibling have any direct or indirect ownership or a controlling interest of 5% or more in any organizations, agencies, institutions, or other entities?
 Yes No

If **Yes**, complete the rest of this form and submit with your application;

If **No**, sign and date this form and submit with your application.

Organization/Agency/Institution/Entity Legal Name and all d/b/as Address, and FEIN Medicaid # or NPI
Owned/Controlled by whom (state relationship to you)_____

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List names, addresses social security numbers for individuals (Owners, Trustees, Board of Directors) and the FEIN (Federal Employer Identification Number) for each organization in which you, your spouse, parent, child, or sibling has a direct or indirect ownership or a controlling interest of 5% or more in each above named agency, institution or organization. If nonprofit or government related, attach a list of the board of directors, commissioners or other persons in authority. If more than one individual is reported and any of these persons are related to another as spouse, parent, child, or sibling, attach a separate sheet listing these individuals and their relationship to each other.

Name	Address	Social Security Number	Relationship of Person to you	Federal Employer Identification Number

6. Type of entity:
 Sole Proprietorship Unincorporated Association Partnership
 Corporation Non Profit Other (Specify) _____

7. Has there been a change of ownership or control within the last 12 months to any of the above listed entities?
 Yes No
 If "Yes", give Date: _____

8. Do you anticipate a change of ownership within the next 12 months to any of the above listed entities?
 Yes No
 If "Yes", When: _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or Secretary of Health and Human Services, as appropriate.

NAME (Please print or type) _____ TITLE(eg., MD, RN, DC, DDS, etc.) _____

SIGNATURE (STAMPS ARE NOT ACCEPTABLE) _____ DATE _____



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

November 5, 2008

Dear Medicaid Nursing Services Provider:

Effective July 16, 2007, the Medicaid program will pay providers of non-institutional pediatric continuous private duty nursing services (including children in Care at Home Waiver Programs) an enhanced rate of thirty percent (30%) added-on to the approved standard hourly rate.¹ The enhanced rate is payable for dates of service on or after January 1, 2007, through December 31, 2008² and has been extended to December 31, 2010. Both Licensed Home Care Services Agency (LHCSA) and independently enrolled nurse providers are eligible to receive the enhanced rate. LHCSA providers can only use the increased rate amount to recruit and retain qualified registered and licensed practical nurses to service these cases on behalf of their agency.

In order to receive reimbursement for the enhanced rate, nursing providers must certify on the enclosed form that the nurse providing the services is trained and experienced to care for the medically fragile pediatric population in a community setting.³ LHCSA providers must certify on behalf of the nurses with whom they contract or whom they employ, that the nurses' training and experience to serve these clients exceeds the minimum New York State Education Department (SED) registered nurse (RN) and licenses practical nurse (LPN) licensure renewal requirements. LHCSA providers must certify that this documentation is maintained and available for inspection on demand. Similarly, nurses who are individually enrolled must certify on their own behalf that they possess the required training and experience, and have verifying documentation.

The attached Certification of Nurse Training and Experience form must be completed, executed and submitted to the Medicaid program through Computer Sciences Corporation (CSC) in order to process the increased rate authorization. Upon receipt of this certification, a new Specialty Code, 579 – Medically Fragile Children, will be added to your Medicaid provider enrollment file. Code 579 authorizes reimbursement of continuous nursing services claims for all children under age 21 at the enhanced rate for eligible service dates. Any provider of private duty nursing services who does not submit the attached certification will not be reimbursed at the enhanced rate.

¹Section 367-r(1-a) of the New York Social Services Law (SSL) authorizes the Medicaid program to reimburse non-institutional pediatric continuous private duty nursing provided to medically fragile children at an enhanced rate, in order to recruit and retain qualified private duty nurses and ensure service delivery to this patient population.

²SSL§ 367-r(1-a) expired on January 1, 2009. Extension to December 31, 2010.

³Medically fragile children are at risk of hospitalization or institutionalization, but are capable of being cared for at home if provided with appropriate home care services, and means any children under age 21 receiving continuous nursing services in a non-institutional setting. SSL § 367-r(1-a), 18 NYCRR § 505.8(g)(6).

The **Billing Instruction** for use in submitting claims with dates of service on or after January 1, 2007 through December 31, 2010 is to enter a **Service Authorization (SA) Exception Code of "7" on the claim**. On the paper claim form (eMedNY 150001), this is entered in Field 25D. Electronically, the SA Exception Code is submitted in the SA Exception Code Segment of Loop 2300 for the 837 Professional claim format. ePACES users will find the SA Exception Code field in the Professional Claim Information Tab – toward the bottom. **PROVIDERS SHOULD ENTER THEIR USUAL AMOUNT CHARGED, WITHOUT INCLUDING THE 30 PERCENT ADD-ON. eMedNY WILL CALCULATE THE 30 PERCENT ADD-ON FOR INCLUSION IN YOUR REIMBURSEMENT.**

If you have any questions regarding this letter, please contact the eMedNY Call Center at 1-800-343-9000. Thank you for your continued support of our efforts to ensure delivery of high quality nursing services for pediatric Medicaid enrollees living in the community.

Sincerely,



Christine Hall-Finney
Director
Provider Relations and Utilization Management
Office of Health Insurance Programs

Enclosure
EMEDNY-432301 (08/09)

**NEW YORK STATE MEDICAID PROGRAM
NON-INSTITUTIONAL PEDIATRIC CONTINUOUS PRIVATE DUTY NURSING SERVICES
CERTIFICATION OF NURSE TRAINING AND EXPERIENCE**

Check appropriate box, complete, sign, and submit to:
Computer Sciences Corporation, PO Box 4610, Rensselaer, NY 12144-4610.

MEDICAID PROVIDERS WHO ARE LICENSED HOME CARE SERVICES AGENCIES (LHCSA's)

Agency Name: _____

Agency's NYS License Number: _____

Medicaid Provider Identification Number: _____

National Provider Identifier (NPI): _____

I certify on behalf of this LHCSA Medicaid provider, that the licensed practical nurses (LPN) and registered nurses (RN) providing non-institutional pediatric continuous private duty nursing services on behalf of this LHCSA, for which an enhanced Medicaid reimbursement rate is claimed, are trained and experienced to provide the care and services ordered under a medically fragile pediatric patient's assessment and plan of care. Training and experience in the care of pediatric medically fragile patients exceeds the minimum New York State Department of Education (SED) RN and LPN licensure renewal requirements. This LHCSA maintains on file, for inspection on demand, documentation of LPN and RN training and experience in the care of pediatric medically fragile patients.

Agency Name (Please Print) _____
Date

Signature of Authorized Officer or Employee _____
Title

Print Name of Authorized Officer or Employee

MEDICAID PROVIDERS WHO ARE INDEPENDENTLY ENROLLED NURSES

RN

LPN

Name: _____

NYS License Number: _____

Medicaid Provider Identification Number: _____

National Provider Identifier (NPI): _____

Please specify training and completion date. Acceptable skills would be inclusive of but not limited to: tracheostomy care, ventilator care, gastrostomy tube insertion/care and feedings (RN and LPN), naso-gastric tube insertion/care and feedings (RN only), and home infusion (RN only but LPN can monitor). LPN/RN maintains, for inspection on demand, documentation of training and experience in the care of pediatric medically fragile patients.

Training	Completion Date
_____	_____
_____	_____
_____	_____

I certify that I am trained and experienced to provide non-institutional pediatric continuous private duty nursing services under a medically fragile pediatric patient's assessment and plan of care.

Name (please print)

Signature

Date