CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services

Andy Beshear
Governor

Division of Administration and Financial Management
1714 Perryville Rd #550
Danville, KY 40422
502-564-4056

Eric C. Friedlander
Secretary

Dear Foster Parent,

First let me say "Thank You" for all you do to provide for the needs of the children that are placed in your care. I know that sometimes it seems that we ask a lot from the foster parents just to meet the needs of our children so that is why I try to make the NEMT Program (Non-Emergency Medical Transportation) as easy and painless as possible.

Enclosed you will find the application packet as well as instructions and tips for filling this out and blank invoices. Please make sure to keep at least one copy of the invoices due to the fact you will be making your own copies as you need them. I would like to give you just a few instructions before you begin:

1. Make sure to date the application the day you receive it because you can start counting your miles from that date forward. The NEMT program does not back date so any trips you make prior to receiving the packet cannot be turned in for reimbursement through this program.
2. Make sure that when you send me back your information that all your names and addresses are all the same on the documentation.
3. ****THIS IS VERY IMPORTANT**** - If you are going on a trip that is not in the county you live or in a surrounding county then you will have to get a referral from the sending physician who is sending you to the doctor but you also have to have a referral from the broker who is covering your region. If you do have to go outside this area then call me. Amanda Rankin at 502-564-4056 and I will give you the name and phone number of your broker.
4. This process takes at least 90 days from start to finish so do not expect to get an acceptance letter before that time. Please hold on to all your invoices until you receive a letter from me telling you that you've been approved. When you get your approval then you can send me all the invoices that you have up to that point and after that you are to mail them in **monthly**.
5. If you have a spouse and you both want to be a provider for transportation then make a copy of the first page of the application and you **both** have to fill it out separately.

If you have any further questions then please do not hesitate to give me a call and once again thank you for your service to the children of Kentucky.

Amanda Rankin

Amanda Rankin
Administrative Specialist III

MAP-572B (Rev. 02/2016)

To be completed by OTD management:

Reviewed by: _____
Date: _____

Commonwealth of Kentucky
Cabinet for Family and Health Services
Department for Medicaid Services

F O S T E R P A R E N T
Transportation
Provider Agreement

To be completed by Department For Medicaid Services:
Sanction checks completed by:
TWIST Date: _____
Signature: _____
Date:

Each individual applying for a Kentucky Medicaid transportation provider number must complete a separate form.

_____, _____
(Print your full name) (Social Security Number)

The applicant agrees to:

- Transport Medicaid recipients to and/or from medical services;
- Obey all applicable federal and state laws and regulations concerning the Kentucky Medicaid Program and the Kentucky Transportation Cabinet (driver's license, automobile/vehicle registration and insurance requirements);
- Not discriminate on the basis in the provision of services due to age, handicap, national origin, race, or sex in the provision of service.
- Keep all records of all transportation services provided to Medicaid recipients for a minimum of five (5) years (letters, statements, etc.) for review purposes;
- Notify the Cabinet for Family and Health Services, Department for Medicaid Services of any name or address change.

I understand there may be civil or criminal penalties if I intentionally defraud the Department for Medicaid Services.

The provider or the Cabinet may terminate this agreement at any time. This constitutes the entire agreement between the Cabinet for Family and Health Services and the provider.

APPLICANT INFORMATION:

Original Signature:_____

Date:_____

Physical Address:_____

_____

Mailing Address:_____

_____

Email Address: _____

Driver's License Number:_____

Residing County:_____

Phone Number:__(_____) _____

(FOR AGENCY USE ONLY)
Department for Medicaid Services

Authorized Signature: _____

Title: _____

Approval Date: _____

(FOR DCBS USE ONLY)

Name: _____

Signature: _____

Approval Date: _____

Background Check Completed (please circle): Y or N

CLEAR FORM

Return form to:
Amanda Rankin, 1714 Perryville Rd #550, Danville, KY 40422

amanda.rankin@ky.gov

NEMT FOSTER PARENT HELPFUL HINTS

1. If your child is medically fragile then no approvals are needed for any doctor visits!!

2. If your child is not medically fragile, then these are the procedures for trips and billing. You must call DAFM, 502-564-4056, for a referral prior to the trip.

    a. All trips that are outside your service area (your county or a surrounding county) will not be paid without a referral from the general practitioner or pediatrician in your county. (Ex: if the area you live in does not have a pediatrician and the surrounding counties do not have a pediatrician then you must go to the GP in your area and they have to give you a referral to take the child outside that area due to not being able to treat the child's medical needs at that office. This would also be the same for a dentist, allergy doctor, etc)
    b. Any trip over 5 hours one way must be approved by Becky Downey. You can email her at becky.downey@ky.gov. You will need to fill out the attached form and send it directly to Becky Downey for approval**. It MUST be submitted at least seven days prior to appointment.**

3. Make sure when you turn in your billing log **at the end of each month** that you have the child's name, county of origin, and their Medicaid number on the billing form.

4. Make sure that you have gotten your doctor's signature for each visit and the reason for the visit. (Not a nurse or receptionist.)

5. You **MUST** fill in the date of the visit and the time you leave the pick-up address and then you also must put the date in again when you leave the doctor's office and the time you leave the office. We will not be able to reimburse you for trips that do not have both the date and time in both spots.

6. Make sure all paperwork is legible! I need to be able to read the form clearly or it will take longer to process.

7. If you are sending in copies of recent driver's license, registration, or insurance cards, then I must be able to see all numbers on these or they will not be accepted by the Department of Transportation. (It is best to send in enlarged copies of your driver's license.)

8. When filling in the type of medical service, you must be specific. You cannot write check-up or doctor visit. Please tell us what the reason for the visit was, such as a doctor visit for an ear infection, eye exam, or physical therapy.

9. **New foster parents wishing to enroll in the NEMT Provider Program need to make sure of the following when sending in their paperwork:**

    a. The paperwork is all legible.
    b. The paperwork must all match – such as the name and address must match on all items. The driver's license name and address must be exactly the same name and address that is on the registration. The Social Security Card must have the same name as the application.
    c. Proof of Insurance must be in the name of the person applying to be a provider. (Ex: If the wife is applying to be a provider and turns in the application then the insurance card cannot be in her husband's name even though she is a covered driver under the policy. You must have an insurance card with the enrolling provider's name, or the Department of Transportation will not accept it.)
    d. Copy of the Social Security Card must be legible.
    e. **Make sure when sending in the application, that you send in the front page of the application, enlarged copy of your driver's license, enlarged copy of the social security card, current vehicle registration, vehicle insurance and foster parent approval letter.**

*Note: You will not mail in your first set of invoices until you receive the Medicaid approval letter in the mail (this could take up to 90 days) and then you can send in all your invoices that have been held pending approval. **After initial application is processed, please send in your invoices monthly.**

If you have any questions or problems, with any of the process then please call Amanda Rankin at 502-564-4056 or email amanda.rankin@ky.gov and she will be able to assist.

Andy Beshear
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
275 East Main Street, 3W -A
Frankfort, Kentucky 40621
Phone: 502-564-3703
Fax: 502-564-6907

Eric Friedlander
SECRETARY

Lesa Dennis
ACTING COMMISSIONER

Date:

****The following is the information needed from the social worker, case worker, parent, foster parent in order to provide prior authorization for travel assistance.****

1. Patient's Name:
2. Patient's DOB:
3. Patient's SSN#:
4. Medicaid ID #:
5. Managed Care Organization ID #:
6. Managed Care Organization Name:
7. Accompanying Parent Name:
8. Address:
9. Phone:
10. Referring Primary Care or Specialty Physician's Name:
11. Physician's Phone Number:
12. Physician's Address:
13. Name of Facility Where appointment is:
14. Facility Address:
15. Facility Phone Number:
16. Time(s) and Date(s) of appointments:
17. Name of Physician or Specialist:
18. Social Worker/Case Manager's Name and Phone Number:

KENTUCKY TRANSPORTATION CABINET NEMT FOSTER PARENT TRANSPORTATION PROVIDER BILLING LOG AND INVOICE

FOSTER CHILD'S NAME : ____________ **COUNTY:** ____________ **NEMT FOSTER PARENT PROVIDER NAME :** ____________

FOSTER CHILD'S MEDICAID ID# : ____________ **REGION:** ________ **NEMT FOSTER PARENT PROVIDER NUMBER :** ____________

DATE:	FOSTER CHILD'S PICK UP ADDRESS	MEDICAL PROVIDER'S NAME and ADDRESS	# OF MILES	RATE	TOTAL $	MEDICAL PROVIDER SIGNATURE:
	Pickup Time:	Drop Off Time:		X $.50	$	

DATE:	MEDICAL PROVIDER'S NAME and ADDRESS	FOSTER CHILD'S PICK UP ADDRESS				
			TYPE OF MEDICAL SERVICE:			
	Pickup Time:	Drop Off Time:		X $.50	$	

DATE:	FOSTER CHILD'S PICK UP ADDRESS	MEDICAL PROVIDER'S NAME and ADDRESS	# OF MILES	RATE	TOTAL $	MEDICAL PROVIDER SIGNATURE:
	Pickup Time:	Drop Off Time:		X $.50	$	

DATE:	MEDICAL PROVIDER'S NAME and ADDRESS	FOSTER CHILD'S PICK UP ADDRESS				
			TYPE OF MEDICAL SERVICE:			
	Pickup Time:	Drop Off Time:		X $.50	$	

DATE:	FOSTER CHILD'S PICK UP ADDRESS	MEDICAL PROVIDER'S NAME and ADDRESS	# OF MILES	RATE	TOTAL $	MEDICAL PROVIDER SIGNATURE:
	Pickup Time:	Drop Off Time:		X $.50	$	

DATE:	MEDICAL PROVIDER'S NAME and ADDRESS	FOSTER CHILD'S PICK UP ADDRESS				
			TYPE OF MEDICAL SERVICE:			
	Pickup Time:	Drop Off Time:		X $.50	$	

TOTAL MILES THIS PAGE = ____________ **X $.50 = $**____________

____
NEMT FOSTER PARENT PROVIDER SIGNATURE

Please return billing log to: Amanda Rankin, CHFS-DCBS, 1714 Perryville Rd #550, Danville, KY 40422
amanda.rankin@ky.gov