KENTUCKY PRESUMPTIVE ELIGIBILITY PROGRAM

PROVIDER ELECTION FORM AND AGREEMENT

Thank you for your interest in becoming a provider in the Kentucky Department for Medicaid Services Presumptive Eligibility (PE) Program. The PE Program Provider Election Form and Agreement is designed for hospitals or specific provider types seeking certification as a Qualified Entity (QE). Please review this form carefully, complete the required fields, and sign the attestation.

PART 1: PROVIDER INFORMATION

Your Name: _____

Are you the authorized contact person for this Provider? Yes ☐ No ☐

Contact Email Address: _____

Contact Phone Number: _____

Legal Name of Hospital/Provider: _____

Provider Number: _____

Business Name of Provider (if different from Legal Name): _____

Hospital/Provider Mailing Address: _____

Service Address (if different from Mailing Address - if multiple locations please list all):

_____

_____

_____

_____

PART 2: OVERVIEW - PROVIDER APPROVAL/ DENIAL PROCESS AND TIMELINES

Approval Overview and Timeline

- After receipt of the Provider Election Form and Agreement, applying providers will be contacted by Department staff within fifteen (15) business days.
- Providers and/or their Determiners (employees or vendors working with patients to process PE applications) will receive contingent approval. Full approval will be granted upon successful completion of the required online training, along with instructions on accessing the training.
- Providers must identify a direct employee of their entity to serve as an **Organization Manager** who will be responsible for:

1. Completing the required online training.
2. Overseeing the day-to-day PE determination activities and Determiners' responsibilities.
3. Managing onboarding and system access for new Determiners and removing access within three (3) business days for those who no longer represent the provider.
4. Ensuring proper record retention, which includes:
    - Maintaining a current list of all active Determiners
    - Keeping a quarterly and annual record of PE screenings.
    - Storing all documentation related to PE applications (including paper Individual Patient Information forms, if used) in the patient's file for a period of no less than three years from the last date of billing).

- Providers are required to ensure that all employees, including the Organization Manager, complete the annual online training requirements.
- Access to the **kynect Self-Service Application Web Portal** will be granted after successful completion of PE Program training.

Denial Overview

If a provider's application is denied, a notice will be sent to the provider contact outlining the denial reason. Most denials result from incomplete or incorrect information on the Provider Election and Agreement Form. In such cases, the provider may correct the errors and resubmit the form for reconsideration.

PART 3: PE PROGRAM PROVIDER ELECTION AGREEMENT

Please select the option that best describes your election:

- o I am a returning provider seeking to re-enroll in the PE Program.
- o I am a new hospital applying to participate in the PE Program.
- o I am a non-hospital provider applying to participate in the PE Program.

Please provide your provider type:

Select

ACKNOWLEDGEMENT

I understand that becoming a certified Qualified Entity (QE) requires compliance with the following:

- ✓ I must be an enrolled Kentucky Medicaid provider.
- ✓ I agree to conduct PE determination activities without any reimbursement from the Department.
- ✓ I will ensure that all PE determinations made on our behalf comply with the rules and regulations of the PE Program.
- ✓ I will ensure that all staff, including vendor staff, involved in Medicaid PE determinations on our behalf are certified by the Department through completion and passing of the Department-approved training.

- ✓ I acknowledge that it is the provider's responsibility to oversee staff and vendor staff conducting PE determinations on our behalf.
- ✓ I agree it is the responsibility of the provider to maintain accurate and secure record-keeping.

By providing my electronic signature, I acknowledge and agree to adhere to the program standards and expectations outlined in this form.

Signature: _____

Date: _____

PART 4: PROVIDER STAFF

Please list the current provider staff and vendor staff who will be responsible for the PE Program roles as outlined below.

Include any provider staff who need to receive communications from the Department regarding the PE Program, including the Authorized Contact with the authority to speak on behalf of the Provider:

Name	Email Address	Phone Number	Staff/Vendor*	If provider has multiple locations, please provide location served
Provider Staff to Receive Department Communications				
Provider Organizational Manager(Must be a direct employee of the Qualified Entity)				
Provider Determiners				

*Vendor annotations please provide the following information:

Name of Vendor _____