

Verification of School Nursing

Beneficiary Name: _____ MID#: _____

Agency Name: _____ NPI#: _____

School System: _____

The child named above is a beneficiary of Private Duty Nursing (PDN) services.

Section A: Providing agency to complete this section

Please circle the appropriate option below.

Yes No The beneficiary has an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), 504 Plan, or Individual Health Plan (IHP).

Yes No Nursing services provided at school are billed to Medicaid by the LEA as outlined in the DMA LEA Policy 10C.

Yes No The beneficiary is attending a private school, per parent preference, and the beneficiary needs medically necessary service during school hours.

Nursing hours provided at school: _____

Mode of transportation to/from school: _____

***Note:** The CMS-485 may include up to 60 hours every calendar year for sick days, adverse weather days, and/or scheduled school closings. Any hours above this limit must be submitted on a change request form as short term intensive services, and be approved by a DMA Nurse Consultant. A parent/caregiver signed notification explaining any unscheduled school absences is required for PDN agency reimbursement of hours worked in the home.

Signature of agency representative: _____ Date: _____

Section B: Parent/Caregiver to complete this section

Missed school hours:

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Date: _____ Reason for absence: _____

Signature of parent/caregiver: _____ Date: _____

***Note:** A current school calendar and this completed form shall be uploaded to NCTracks as an attachment to the Prior Approval request.