MAP 735
(12/06)

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

Quarterly Certification of State Expenditures By School Districts

Department for Medicaid Services
Division of Administration and Financial Management
275 East Main Street, 6W-C
Frankfort, Kentucky 40621

Dear Sirs:

I, as the financial officer of the ____________________School District, am charged with the duties of supervising the administration of the provision and billing for school-based health services provided under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school district has expended the total computable amount of the state's share of public, non-federal matching funds and the federal share of medical claims billed to the state Medicaid agency for school-based health services provided to eligible Medicaid students during the ______________________________ quarter.

I also certify that the school district's certified expenditures were incurred in accordance with provisions of Kentucky's policies for the services. These certified expenditures are separately identified and supported in our accounting system.

____
Medicaid Provider Number

____
Name (please print)

____
Signature

____
Title

____
Date

1. Enter the name of the school district.
2. Enter the names of the months in each calendar quarter. (For example, enter January, February and March.)
3. Must be submitted no later than April 14, July 14, October 14, or January 14 of each year.
4. Form may be reproduced as needed.