 OIG-1:210-A, August 2022

**Quarterly Report**

**Health Care Services Agency**

* If you have questions regarding this quarterly reporting form, please call (502) 564–7963.
* This form and its accompanying attachments shall be submitted by February 1, May 1, August 1, and November 1.
* Please return this form and all required documents to:

Cabinet for Health and Family Services

Office of Inspector General

Division of Health Care

275 E. Main St., 5 E-A

Frankfort, KY 40621

**A. Identification**

1. Agency Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Agency Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Agency City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. Employee Roster:**

In accordance with KRS 216.728, please submit an attachment with the following information for **each** direct care staff person:

* Name;
* Professional licensure or certification;
* Assigned location and name of facility;
* Length of time the direct care staff person has been assigned to the assisted-living facility, long-term care facility, or hospital; and
* Total hours worked.

**C. Invoices:**

In accordance with KRS 216.728, please submit the following:

* Copies of invoices submitted to each Medicare/Medicaid certified long-term care facility or hospital; and
* Proof of payment by the long-term care facility or hospital.

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 Signature of Authorized Representative Title

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 Name (please print or type) Date

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 Email Address of Authorized Representative Phone Number of Authorized Representative