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.

______________________________________    ______________________________________
Signature of Authorized Representative       Title

______________________________________    ______________________________________
Name (please print or type)           Date

______________________________________    ______________________________________
Email Address of Authorized Representative     Phone Number of Authorized Representative