**Qualified Residential Treatment Program (QRTP) Reimbursement Form**

### Instructions: Please ensure that all applicable parts of this form are completed legibly and in their entirety. If you have questions regarding this form, please contact your local Community Based Care (CBC) lead agency.

This form is intended for Community Based Care (CBC) Lead Agencies who are working in partnership with one or more licensed Child Caring Agencies (CCA) who are seeking or who have already received a QRTP credential. The reimbursement of the expenses will assist CCA providers in aligning with the federal and state licensing standards.

This form must be completed by the designated representative of the CCA provider who signed the application for licensure. Please enter the expense of each applicable item and provide supporting documentation.

 **Section I: General Information**

Name of designated representative:

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Name of Child Caring Agency:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Number :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell number of designated representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the local Community Based Care Agency:

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Bed Capacity: \_\_\_\_\_

##

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| --- |
| **Reimbursement request** |
|  | Total Cost of item | **Amount of reimbursement request** |
| **65C-46.021 DCF Requirements** |  |  |
| Training(s)  |  |  |
| Registered or licensed nursing staff and other licensed clinical staff  |  |  |
| Accreditation |  |  |
| Trauma-informed treatment model |  |  |
|  Basic Service Requirements |  |  |
| Family-based aftercare support services (6 months) |  |  |
| Background Screening under Chapter 435 and 39, F.S. |  |  |
| List “other” items here |  |  |
| List “other” items here |  |  |
| List “other” items here |  |  |
| **65E-9 AHCA Requirements** |  |  |
| AHCA application |  |  |
| Medicaid number  |  |  |
| Administrative cost  |  |  |
| Physical Structure pursuant to 65e-9 |  |  |
| List “other” items here |  |  |
| List “other” items here |  |  |
| List “other” items here |  |  |
| List “other” items here |  |  |
| **Total** |  |  |

##

***Supporting Documents should include but not limited to receipts of expenses, contracts/working agreements between CCA providers and CBC, and picture of items remodeled/fixed to comply with QRTP Credential requirements.***