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Kansas
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Laura Howard, Secretary

Laura Kelly, Governor

MEMORANDUM

TO: Supplemental Healthcare Services Agency

FROM: Tabetha Mojica, Director of Health Occupational Credentialing, KDADS

RE: KS SB 28 and KS HB 2551 Registration/Fee

DATE: June 28, 2024

For the purpose of providing oversight of supplemental healthcare services agencies through annual registration and quarterly reporting for fiscal year 2025. Effective July 1, 2024, Kansas Department for Aging and Disability Services (KDADS) shall require a supplemental healthcare services agency to register and pay a registration fee of $2,035.

The statute HB2551 defines a supplemental healthcare services agency ***"means a person, firm, corporation, partnership or association engaged in for-hire business of providing or procuring temporary employment in healthcare facilities for healthcare personnel, including a temporary nursing staffing agency, or operates a digital website or digital smartphone application that facilitates the provision of the engagement of healthcare personnel and accepts requests for healthcare personnel through a digital website or digital smartphone application***":
Goes on further to define temporary nursing staffing agency ***"means a person, firm, corporation, partnership or association doing business within the state that supplies, on a temporary basis, registered nurses or licensed practical nurses to a hospital, nursing home or other facility requiring such services."***

- To register, an agency must submit this "Registration for Supplemental Healthcare Services Agency Form." along with the applicable registration fee of $2,035. Each physical location of a qualifying agency must submit a separate application; and
- On a quarterly basis each registered supplemental healthcare services agency must submit a report to KDADS. The report must include each healthcare facility that participates in Medicare or Medicaid that are provided with supplemental nurse staff from the agency. The report shall include a detailed list of the average amount that the supplemental healthcare services agency charged the healthcare facility for each individual agency employee category and the supplemental healthcare services agency paid to employees in each individual employee category.

Please note: This is not a license. You will not receive a certificate. The email response your agency contact receives from KDADS is the confirmation of your registration. ALL DATA SUBMITTED ON THIS REGISTRATION FORM AND QUARTERLY REPORTS IS CONSIDERED PUBLIC INFORMATION UPON SUBMISSION.

Registration for Supplemental Healthcare Services Agency

Identification

Each separate location of the supplemental nursing services agency **must have a separate registration and pay a separate registration fee of $2,035.** Please answer all questions completely, accurately, and legibly to avoid unnecessary delay.

Facility ID: _____ EIN# _____

(Facility ID Number provided by KDADS/HOC to submit Criminal Record Checks, ex: Q111111 leave blank if N/A)

Agency Name: _____

DBA: _____

(If different from Agency Name)

Agency Street Address: _____

Agency City/State/Zip: _____

Telephone Number: (___) _____

Point of Contact Name: _____

(First Name and Last Name)

Email Address: _____

(Email used in the field above will be used in official communications with the department. The email should be an address accessible by **one** person who will act as the company's administrator.)

Date the Agency started operating: ____/____/_____

Date the Agency started operating in Kansas, if different from above date: ____/____/_____

Supplemental Nursing Services/Health Care Facility Type

Select below what type of nursing services will be provided or procured and in which type of health care facility along with that facilities ID #.

Supplemental Nursing Services	**Type of Health Care Facility** ***Check all that apply along with facility ID#'s (Ex: N000000)***
Registered Nurses	☐ Skilled Nursing Facility/Nursing Facility: _____ _____ ☐ LTC Unit in a Hospital: _____ ☐ Hospital: _____ ☐ Assisted Living: _____

Licensed Practical Nurses	☐ Skilled Nursing Facility/Nursing Facility: _____ _____ ☐ LTC Unit in a Hospital: _____ ☐ Hospital: _____ ☐ Assisted Living: _____
Nurse Aides	☐ Skilled Nursing Facility/Nursing Facility: _____ _____ ☐ LTC Unit in a Hospital: _____ ☐ Hospital: _____ ☐ Assisted Living: _____
Medication Aide	☐ Skilled Nursing Facility/Nursing Facility: _____ _____ ☐ LTC Unit in a Hospital: _____ ☐ Hospital: _____ ☐ Assisted Living: _____

Registration Fee/Verification:

- Enclose the $2,035.00 registration fee
  By check or money order make payable to "KDADS"
  Mail: KDADS/HOC
  503 S. Kansas Ave
  Topeka KS, 66605

OR

By Credit Card (Required form attached) Fax:
785-296-3075 or email:

To the best of my knowledge, I certify that the information provided on this form is accurate and complete. Along with minimum licensing, training, and continuing education standards for the position in which the employee will be working.

Signature of authorized representative: _____

Title: _____ Date: ____/____/____

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION HEALTH
OCCUPATIONS CREDENTIALING
CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD

NAME OF SUPPLEMENTAL STAFFING AGENCY: _____
Please Print

As payment of fees for:
_____ *Registration Fee* **Fee amount paid: $2035.00**

VISA OR MASTERCARD NUMBER: _____ _____ _____ _____

EXPIRATION DATE: _____/_____

_____ _____
PRINTED NAME OF CARD HOLDER (REQUIRED) AUTHORIZED SIGNATURE (REQUIRED)

Credit Card company service fee of 3.04% will be added to the total

FOR OFFICE USE ONLY:		
AMOUNT	SERVICE FEE: _____	TOTAL CHARGED

TM 05.06.2024