

**Date:**

**To:**

**Cc:** [NFCMP@medicaid.ohio.gov](mailto:NFCMP@medicaid.ohio.gov); [CMP-Info@cms.hhs.gov](mailto:CMP-Info@cms.hhs.gov); [kaitlin.lavin@cms.hhs.gov](mailto:kaitlin.lavin@cms.hhs.gov);  
[QualityAssurance@cms.hhs.gov](mailto:QualityAssurance@cms.hhs.gov);

**Subject: State Approval of Request to Use CMP Funds for COVID-19 Communicative Technology**

The State of Ohio has approved the COVID-19 Communicative Technology application for the facility and the amount identified below, to implement COVID-19 communicative technology project:

Facility Name	CMS (CCN) Certification Number	Number of Certified Facility Beds	Type of Device (e.g. Tablet, Webcam.)	Cost per Device	Number of Devices	Total Cost per Facility
			See Attached Application	See Attached	See Attached	See Attached
<b>TOTAL PROJECT COST (per facility)</b>						
<b>TOTAL APPROVED AMOUNT (per facility)</b>						

The state confirms all required application parameters were met. To receive reimbursement, **please submit to [NFCMP@medicaid.ohio.gov](mailto:NFCMP@medicaid.ohio.gov) the following information in order for us to process your request for reimbursement:**

1. Dated **receipt** including list of items purchased, price per unit, and total price
2. Contact name and phone number
3. Your facility's name and 7-digit Medicaid provider number
4. Name and full address for where payment should be sent
5. Tax identification number
6. Subject line of email - enter "CMP Receipt-XXXXXXX" where XXXXXXX is the facility's 7 digit Medicaid number

As a reminder, reimbursement is not eligible for shipping and taxes and will not exceed the amount approved by ODM.

Thank you,

ODM CMP Team