STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
55 FARMINGTON AVENUE HARTFORD, CT 06105-3725
Phone: 860-424-5386 Fax: 860-424-4812

School Based Medicaid Program
Authorization of Designated Program Contacts

The purpose of this form is to identify the individual designated by the district to deliver information necessary for the administration of the following processes on behalf of the district. As appropriate to each designation, these individuals will be given User IDs to access online website applications to act on behalf of your school district for the purpose of the Medicaid program. Billing Vendors may not be designated as primary contact but may be listed as a secondary contact for the district.

School District Name:_____ LEA Number: _____

RMTS Coordinator: Responsible for RMTS Participant Information, including participants and work schedules, as well as monitoring time study participating and managing any 'change of status' issues.

Name:		Phone:	
Title:		Email:	

Administrative Activity Claim Coordinator: Responsible for submitting the quarterly staff salary and benefit information and other allowed expenditure data for the quarterly AAC claims.

Name:		Phone:	
Title:		Email:	

Cost Report Coordinator: Responsible for submitting the annual Direct Medical Services and Transportation Cost Report information for the school district.

Name:		Phone:	
Title:		Email:	

Billing Vendor: Secondary point of contact on behalf of the school district.

Name:		Phone:	
Title:		Email:	

School District Authorization:

_____ _____
Printed Name Signature

_____ _____
Title of District Representative Date

Please submit completed form to:

CT Department of Social Services
Email: dss.sbch@ct.gov

AND

University of Massachusetts
Email: schoolbasedclaiming@umassmed.edu
Fax: (508) 856-7643