Local Education Agency (LEA) Certification
for
Release of Medicaid Claim File

I,_____ (designated LEA representative), certify that the data received via this request will solely be used for the purposes of Medicaid claiming and auditing.

For all students whose data is requested by the LEA, I certify that the LEA provided the services for which reimbursement is being sought AND a valid parental consent is on file for the period for which the claims are being submitted.

As the designated LEA representative, I certify that the confidentiality of any and all data and information viewed or accessed as a result of this data file transmission will be preserved, as required by the Family Education Rights and Privacy Act (FERPA), and any and all applicable confidentiality laws and regulations.

In addition, I confirm that the LEA will:

a. Not disclose or give access to any data or information to any unauthorized party whether an individual, organization or entity (all parties are unauthorized unless they have been identified by the OSSE as authorized to have such information); and

b. Maintain all data and information obtained in a secure computer environment and not copy, reproduce or transmit data obtained except as necessary to fulfill the purpose of the original request or assignment. All copies of data of any type, including any modifications or additions to data from any source that contains information regarding individual students, are subject to the provisions of this appointment in the same manner as the original data. The ability to access or maintain data shall not under any circumstances transfer to any other person, institution or entity.

If, upon receipt of the requested data file, the LEA identifies a student in the file set who was not served by the LEA, the LEA will notify OSSE immediately.

By signing below, I agree to the above conditions.

I CERTIFY THAT I HAVE THE AUTHORITY TO MAKE THE ABOVE ASSURANCES ON BEHALF OF THE LEA:	
_____ Printed Name	_____ Title
_____ Signature	_____ Date
_____ LEA	