**State of Virginia**

**Department of Medical Assistance Services**

<https://www.dmas.virginia.gov/for-providers/school-based-services/>

**School-Based Services**

**Authorization of Designated LEA Contacts**

The purpose of this form is to identify the individuals designated by the school division to deliver information necessary for the administration of the following processes on behalf of the school division.

School Division Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RMTS Coordinator(s):** Responsible for managing participant lists and calendars before the start of each quarter. During the quarter RMTS Coordinators are required to update participant data as needed, submit Change of Status requests, and monitor that moments are answered within the allowed grace period.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Email: |  |
| Name: |  | Email: |  |

**Student Eligibility Matching**: The below personnel are authorized to Upload your School Divisions’ student roster into the Student Medicaid Eligibility Matching System, and also who is authorized to review the student data within the matching system and make decisions about ‘Possible Matches.’ These designees can both be the same person, or the different functions can be separated between more than one individual.

|  |  |  |  |
| --- | --- | --- | --- |
| Uploader Name:  (Also Reviewer (Y/N)) |  | Email: |  |
| Reviewer Name: |  | Email: |  |
| Reviewer Name: |  | Email: |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Email: |  |
| Name: |  | Email: |  |

**Cost Report Preparer(s)**: Responsible for submitting the annual Direct Medical Services and Transportation Cost Report information for the school Division.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Email: |  |
| Name: |  | Email: |  |

**School Division Authorization**:

Printed Name Signature

Title of Division Representative Date

Please scan the completed and signed form and email to:

University of Massachusetts Chan Medical School

School Based Medicaid Program

Email: [RMTSHelp@umassmed.edu](mailto:RMTSHelp@umassmed.edu)