REQUEST and ATTESTATION FOR ENHANCED ePACES SEARCH ACCESS

*To request access for enhanced search access on ePACES, please complete and **return this form to**:*

eMedNY
PO Box 4610
Rensselaer, NY 12144-4610

By signing this document, [Facility Representative Name and Title] of [Article 28 Facility] attests that [Provider Name and Title] is a current employee affiliated with [Article 28 Facility] and its School-Based Health Center (SBHC) Program. Both [Article 28 Facility] and [Provider Name] are enrolled with Medicaid and recognize approval and processing of this completed form will result in an update to [Article 28 Facility]'s and [Provider Name]'s Medicaid files. [Facility Representative Name] and [Provider Name] attest that [Article 28 Facility] and [Provider Name] accept full liability for ensuring appropriate utilization of this enhanced search access for obtaining the insurance information of SBHC enrolled children as defined below.

I acknowledge that all methods for accessing and utilizing pertinent Protected Health Information (PHI) must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other applicable confidentiality requirements. Additionally, I acknowledge that this enhanced search access may only be utilized by the affiliated provider, solely for use for the SBHC Program. This access does not extend to other staff or programs under or outside the auspices of [Article 28 Facility]'s SBHC Program.

Any inquiries from the New York State Department of Health (the Department) or its subcontractors related to this access or its utilization must be responded to in a timely manner. If there is a termination of Medicaid enrollment, a termination of employment, or change in operating status of [Article 28 Facility], the SBHC Program, or the affiliated provider impacting eligibility for this access, notification will be submitted to the Department by sending a completed copy of the termination request form to eMedNY, PO Box 4610, Rensselaer, NY 12144-4610 prior to the effective date of the change or within 48 hours of the determination to make such change where such a determination is effective immediately. Failure to provide appropriate notification may result in immediate termination of this enhanced access for all providers affiliated with [Article 28 Facility].

I recognize utilization of this enhanced search access may begin upon receipt of an approval letter generated at the time this form is processed by the Department. Approval will remain in effect until there is a change in Medicaid enrollment status of [Provider Name] or [Article 28 Facility], documentation is submitted requesting termination of this search access by [Provider Name] or [Article 28 Facility], or the Department has determined [Provider Name] or [Article 28 Facility] no longer meet eligibility requirements for this enhanced search access.

- By signing this document, I verify that I have reviewed and understand the associated instruction and/or guidance materials pertaining to my new data access.
- I shall abide by the instruction and/or guidance materials.
- I agree that I can only utilize this enhanced search access solely for the purpose of collecting and/or updating SBHC patient health insurance information and it may not be utilized for any other purpose.
- I understand that Medicaid data is sensitive in nature and must be protected in accordance with the law.
- I understand the responsibilities in maintaining the confidentiality of personal health related information, including, but not limited to, Medicaid information.
- I agree to not redisclose any personal health information, except as authorized by law.
- I understand and agree that failure to comply with HIPAA may lead to corrective disciplinary actions and may result in additional penalties, up to and including monetary fines and criminal prosecution.
- I acknowledge that others may act in reliance on this statement and that I will comply with the representations made in this attestation. I understand that the New York State Department of Health will use all available legal remedies if I fail to comply with these terms and conditions.

Facility Medicaid Management Information System (MMIS) Number	**Provider MMIS**
Facility National Provider ID (NPI)	**Provider NPI**
Facility Representative Name	**Provider Name**
Facility Representative Signature	**Provider Signature**
Date	**Date**