ATTACHMENT A
(To be completed by Business Associate)

DMAS/School Board Name
Master BAA Agreement #

Reference Section III Special Provisions to General Conditions

10. This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

a. The names and contact information for at least one primary contact individual from each party to this Agreement.

Contact: Chandra Shrestha
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
(804) 371-2446
Chandra.shrestha@dmas.virginia.gov

Contact:
School Name:
Address:
Phone Number:
Email Address:

b. Complete list of all individuals, whether employees or direct contactors, of Business Associate who shall be authorized to access Covered Entity's PHI.

c. List of the specific data elements required by Business Associate in order to carry out the purpose of this Agreement.
School division county name
School division name
Medicaid recipient (student) last name, first name, and middle initial
Medicaid recipient (student) address, including state and zip code
School division locality code (fips code)
Medicaid recipient (student) birth date
Medicaid recipient (student) sex: M or F

Medicaid recipient (student) Medicaid program type: Medicaid, Medicaid Expansion, or FAMIS
Medicaid recipient (student) parental consent: Y or N
Medicaid recipient (student) ID #
Medicaid recipient (student) SSN

d. Purposes for which such data is required.

The data is required to determine the percentages of Medicaid, Medicaid Expansion, and FAMIS eligible students that are used to calculate Medicaid reimbursable expenditures.

e. Description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.