PENNSYLVANIA SCHOOL-BASED ACCESS PROGRAM (SBAP)
ELECTRONIC SIGNATURE VERIFICATION STATEMENT FOR MAXCAPTURE DATA ENTRY

This Electronic Signature Verification Statement is intended to document my signature as part of the documentation required for compliance with Pennsylvania's School-Based ACCESS Program (SBAP) requirements. I understand that this electronic signature is created with a unique combination of my computer login name and secure password. This unique combination is to ensure that all documentation completed under this combination is done by me.

Use of the electronic signatures, for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a handwritten signature on a document.

By signing this statement, I confirm that I will keep my password secure and that I will not disclose this information to others. I also confirm that all documentation entered under my login name and password is true and correct. This signature verification form will be in effect until such date that the signatory party's responsibilities within MAXCapture change.

☐ I have read and understand the statements above, and I agree that I will comply with these statements. (Form is invalid if this is not checked by signatory party.)

Local Education Agency: _____

Name (Printed): _____ MAXCapture User ID: _____

Job Title: _____

Use of MAXCapture (check all that apply):

☐ I use MAXCapture to enter documentation of direct health-related services that I personally provided to the student.

☐ I use MAXCapture to log service documentation of direct health-related services provided by the actual service providers.

Note: "MAXCapture Data Entry of Direct Health-Related Services Agreement" additionally required from LEA. Original documentation must be maintained per State Medicaid Regulations in 55 Pa. Code § 1101.51)

☐ I use MAXCapture to approve documentation of direct health-related services that require supervisory signature per Section 3 of the SBAP Handbook and/or to approve service submission to the Medicaid Management Information System for billing (ACCESS Coordinator role).

Signature: _____ Date: _____

Retain this document for your records in the case of an audit or review.

Pennsylvania Department of Human Services
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Email: RA-PWSBAP@pa.gov