



State of Connecticut Department of Social Services  
 School Based Child Health Program  
 School District Contact Information Update Form

The purpose of this form is to provide the DSS SBCH program with current contact information for your district as it relates to the various aspects of the program. Please only list relevant school staff information in the numbered areas on the following pages.

**Instructions:**

- ❖ Please include your School District Name, LEA #, the name and title of the person completing the form, and the date the form is completed in the areas provided.
- ❖ Please indicate who the **primary contact** is for each of the identified areas. **Note: For Time Study Coordination purposes, only 1 individual may be listed. Please refer to Page 5 labeled “Time Study Coordinator Responsibilities” for information pertaining to the role of the Time Study Coordinator within the SBCH program.** You may list up to 3 contacts for all other areas.
- ❖ Please enter the applicable code(s) below when providing contact information:  
**N=New, C= Current, R=Remove, P=Primary**

For example: John Smith is a new contact, but also the primary contact. He is entered as follows:

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title
N,P	John Smith	jsmith@isp.com	860-555-1234 x 2	Director of Student Services

- ❖ If information for your district changes after submitting this form, please note that this form may be used on an ongoing basis to keep contact information up to date with DSS.
- ❖ All updates should be forwarded to DSS as soon as a change at your school occurs to ensure proper delivery/notification of valuable and pertinent program information.
- ❖ Please note that billing vendor information is provided **separately on page 5** of this document. Please include your billing vendor information (if applicable) even if the information remains unchanged from what is currently in place.
- ❖ Information pertaining to secure email transmission items (those in red) may require additional steps. Please be sure to read the additional information provided in each of these sections.
- ❖ Completed forms may be submitted by email to [DSS.SBCH@ct.gov](mailto:DSS.SBCH@ct.gov) or by fax to 860-424-4812. Please choose one method. Please **do not** send to individual staff email addresses.
- ❖ Please note that changes in a school’s mailing address **must be** submitted in writing on school letter head via postal mail, fax or by email as a scanned pdf file attachment using the following contact information:  
 Department of Social Services  
 Reimbursement & Certificate of Need  
 55 Farmington Avenue, 9<sup>th</sup> Floor  
 Hartford, CT 06105  
 Email: [DSS.SBCH@ct.gov](mailto:DSS.SBCH@ct.gov); Fax: 860-424-4812



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**Roles and Responsibilities of the Time Study Coordinator**

As a means to provide guidance and assistance the district in identifying an individual to serve as the Time Study Coordinator, DSS has compiled a listing of the tasks associated with this role throughout the school year that will be the responsibility of the individual selected. It is important to note that the individual selected should remain as the Time Study Coordinator for the entire school year so as to allow for consistency in reporting and managing all aspects associated with the Time Study.

As Time Study Coordinator (TSC), the following tasks will need completion during the Random Moment Time Study (RMTS):

- Work directly with the UMMS (University of Massachusetts Medical School) staff and DSS staff regarding questions, time study participant lists, technical issues, etc. This is an ongoing task.
- Review System Technical Specifications Document with technical staff. This is an annual task.
- Complete RMTS coordinator training regarding calendar and hour information, system reports, compliance and other duties.
- Update participant lists, calendars and hours using established format/forms and by established deadlines. This is a quarterly task.
- Provide notification of RMTS participant changes (such as medical leave, unpaid leave, etc.) to UMMS within established deadlines using the required form. This is an ongoing task.
- Provide participant training when necessary. This is an ongoing task.
- Monitor participation in the RMTS through the use of live system reports, email reminders, and notifications. This is an ongoing task.
- Answer questions pertaining to the RMTS received from Participants; if unable to answer, the TSC will be the first point of contact between the district and UMMS / DSS. This is an ongoing task.

As a reminder, a single individual is selected for the role of Time Study Coordinator. This individual can be either a school district staff member or a contractor/vendor staff member. Please consider all of the above mentioned items in determining who within your district would best serve in this role. The Department of Social Services would like to thank you for your prompt response to the above request and looks forward to working with you as we continue to make improvements in the School Based Child Health program.



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School District Name: \_\_\_\_\_ LEA #: \_\_\_\_\_  
 Completed by Name & Title: \_\_\_\_\_  
 Date Completed: \_\_\_\_\_

1. **Administrative Requests/General Correspondence:** This includes School Calendar Requests, General Announcements, etc. Information is sent to schools via standard email transmission.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title

2. **Student Enrollment and IEP Statistics (snap-shot) Requests/Correspondence:** Information is sent to schools via standard email transmission.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title

3. **Cost Report Requests/Correspondence:** This includes requests for additional information (RAI's), employee payroll information, Settlement and Certification information. Information is sent to schools via standard email transmission.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title

4. **Time Study Coordinator /Correspondence:** This correspondence includes employee related requests, communication from UMM regarding Time Studies, and bulletins/updates pertaining to the Time Study aspects of the program. **Only 1 contact may be entered in this area.** Information is sent to schools via standard email transmission from both DSS and UMMS.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title

5. **Medicaid Billing & Payments Correspondence:** Information is sent to schools via standard email transmission.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title



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6. **Correspondence Containing Student Protected Health Information (PHI)\*:** Information is sent to schools via **SECURE\*\*** email transmission.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title

\* PHI includes individually identifiable health information such as name, address, birth date, Social Security number, address, etc. Per the Health Insurance Portability and Accountability Act of 1996 (HIPAA), DSS must assure that an individuals' health information is properly protected.

\*\*Please refer to the document "DSS Tumbleweed Instructions for External Users: (available on the SBCH website at <http://www.ct.gov/dss/cwp/view.asp?a=2349&q=527078>) for instructions on how to access a secure email that has been sent by the Department of Social Services. Recipients will need to establish a password in order to retrieve a securely sent email. The instructions provide instructions on how to complete this process.

7. **Access & Notification of Monthly Medicaid Eligibility Download Lists:** Information is obtained by logging onto the Department's **SECURE\*\*\*** server site.

**Important Note:** Staff not listed in this section as "Current" will be removed from the Monthly Medicaid Eligibility Download List secure access. It is important that only current school staff involved with the SBCH program have access to this data. Please let DSS know immediately when a staff member is no longer with the District, or is no longer working in this function, so that they may be removed from the Monthly Medicaid Eligibility Download List secure access.

N, C, R or P	Staff Name	Email Address	Phone & Ext.	Title

\*\*\*For those who do not have access, the following steps must be taken to gain access to the Tumbleweed Secure Transport Server in addition to being listed in the table above:

- a. A formal request (on District Letterhead) must be sent to DSS (by postal mail, fax or as a pdf attachment in email) with the following information provided for staff and/or vendor personnel that should be given access to the Secure Server:
  - School District Name and Number (town number)
  - School District's Address
  - Provider ID
  - Name of person to be removed (if applicable)
  - Name and Title of person to be added
  - Address, Email Address, Phone Number, and Fax Number
  
- b. After the request has been submitted to DSS, the new school contact(s) will receive 2 emails from DSS' IT Department. The first email will confirm access and provide instruction on how to access the Tumbleweed Secure Transport Server. The second email will be sent securely. This secure email will provide the userid and password necessary to access the Secure Server.



## Billing Vendor Information and Authorization

In completing this area, the school district authorizes the Billing Vendor listed below to receive information for their school for the indicated areas of the SBCH program. **This area should be completed by the School, not the billing vendor. This form must be completed regardless if there are no changes to the information currently on file.**

**Vendor Company Information:**

Please check one:                     New Vendor                     Existing Vendor

Billing Vendor Name	Mailing Address	City, State Zip Code	Phone #

**Vendor Representative Information:**

Contact Name	Contact Email	Contact Phone #	Contact Fax #

**Authorized to receive information/notification for:** (please place an "x" in the areas you are providing authorization for)

Admin Requests/ General Information	Student Enrollment & IEP Stats	Cost Reports	Time Study Coordinator	Time Study Correspondence (excluding passwords)	Medicaid Billing & Payments Information	Student PHI Information	Access & Notification- Monthly Medicaid Eligibility Download Lists

Signature of Individual Completing this form: \_\_\_\_\_

Name (printed): \_\_\_\_\_

Date Signed: \_\_\_\_\_

**For DSS Use Only:**

Received date: \_\_\_\_\_ Update completed date: \_\_\_\_\_

Entered in contacts file:  Yes                     No                    Stored in School electronic file:  Yes  No  
 Follow up necessary:  Yes Reason: \_\_\_\_\_