

Provider #
National Provider Identifier
DHCS Use Only

**STATEMENT OF
COMMITMENT TO REINVEST**

Local Educational Agency _____
Hereby certifies that:

1. A local collaborative has been formed;
2. The local collaborative will include among its responsibilities the decision making process regarding the reinvestment of funds made available through participation in the LEA Medi-Cal Billing Option; and
3. The reinvestment of funds will remain within the school-linked support services identified in provision (7) of the Provider Participation Agreement.

Signatures of the local collaborative partners below indicate an understanding of and commitment to the above statement.

LEA COLLABORATIVE PARTNERS

Name: _____ Signature Date	Name: _____ Signature Date
Title _____	Title _____
Organization: _____	Organization: _____
Name: _____ Signature Date	Name: _____ Signature Date
Title _____	Title _____
Organization: _____	Organization: _____
Name: _____ Signature Date	Name: _____ Signature Date
Title _____	Title _____
Organization: _____	Organization: _____
Name: _____ Signature Date	Name: _____ Signature Date
Name: _____ Signature Date	Name: _____ Signature Date
Title _____	Title _____
Organization: _____	Organization: _____

Attachment 2 (Continued)
LEA Medi-Cal Provider Participation Agreement

Name: _____
Signature Date

Title _____

Organization: _____

Name: _____
Signature Date

Title _____

Organization: _____