



Schenectady County Children with  
Special Needs Annual Attestation  
2024-2025 Agency Billing Provider  
CPSE Portal Form

Agency Name: \_\_\_\_\_

Authorized Billing Representative's Name: \_\_\_\_\_  
Please Print

Title: \_\_\_\_\_

Agency NPI number: \_\_\_\_\_

e-mail: \_\_\_\_\_  
(confidential)

Phone: \_\_\_\_\_

I certify that I understand the entry of my PIN will serve as a digital signature on all electronic vouchers submitted to Schenectady County via CPSE Portal. By entering my pin number, I certify that on the information billed, those named children received the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant Federal, State and Local Laws and Regulations governing the Medicaid process. I further certify that I will maintain confidentiality of my logon password and PIN, and if I suspect or have knowledge of anyone else using it, I will report it immediately to Schenectady County Children with Special Needs Program.

Authorized billing representative signature:

\_\_\_\_\_

Director's Signature: \_\_\_\_\_  
(Director's signature is also needed if he/she is not the authorized billing representative listed on this form.)

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

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***For County Use Only:***

Entered: \_\_\_\_\_