



# **AUTHORIZED PURCHASER FORM**

## **School Incentive Funds**

### **SY 25-26**

PLEASE provide the following information to the Medicaid Office. Only the authorized purchasers listed will be able to utilize the incentive funds for your school. Thank you.

#### **AUTHORIZED PURCHASER REGISTRATION**

Print Name:

School Name:

Phone#:

Email:

#### **ALTERNATE PURCHASER**

Print Name:

Email:

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Primary Authorized Purchaser Signature