

**Commonwealth of Massachusetts**  
**Center for Health Information & Analysis (CHIA)**  
**Acknowledgement of Conditions Upon Receipt of Medicaid Data**

This Acknowledgment supplements the Data Use Agreement (“DUA”) dated \_\_\_\_\_ between the Center for Health Information and Analysis (“CHIA”) and

\_\_\_\_\_ hereinafter referred to as “Recipient”.

This Acknowledgment pertains to the project entitled:

\_\_\_\_\_ as described in the Recipient’s Data Application for data from the Massachusetts All Payer Claims Database (“APCD”).

This Acknowledgment is effective as of the date of execution below. To the extent that this Acknowledgment is inconsistent with any terms in the DUA, this Acknowledgment modifies and overrides the DUA, which shall otherwise remain in full force and effect.

The undersigned Recipient hereby acknowledges that:

- Pursuant to an interagency service agreement between CHIA and MassHealth, CHIA submitted the Recipient’s request for Medicaid data from the APCD to MassHealth for review to determine whether the request is “directly connected” to the administration of the Medicaid program;
- MassHealth has approved the request contingent upon the following requirement(s):
  - the Recipient shall provide MassHealth with the results of its analysis of the Medicaid data.

The undersigned Recipient hereby agrees to comply with the above requirement(s), as a condition of receiving Medicaid data from CHIA. The Recipient acknowledges that the above condition(s) are hereby incorporated into the Recipient’s DUA with CHIA as obligations of the Recipient and that, as such, failure to comply with any of the listed conditions could result in denial of future access to any CHIA Data, termination of current access to CHIA Data, and/or a demand for immediate return or destruction of all CHIA data.

On behalf of the Recipient the undersigned individual hereby attests that he or she is authorized to legally bind the Recipient to the terms of this Acknowledgment and agrees to all the terms specified herein.

Name of authorized signer:		Organization:	
Street Address:	City:	State:	ZIP Code:
Office Telephone ( <i>Include Area Code</i> ):		E-Mail Address ( <i>If applicable</i> ):	
Signature:	Title:	Date:	