

**SOCIAL SECURITY ADMINISTRATION SECURITY TRAINING**

**Individual Training**

I \_\_\_\_\_, certify that I have reviewed the following training on-line  
(Printed Name)  
and understand the penalties for unauthorized disclosures:

**Social Security Administration Contract Power Point Training**  
(located at <http://www.dhhs.state.nc.us/dma/county/medicaidtraining.htm>)

I understand that the contracts and attachments, between the North Carolina Department of Health and Human Services and the Social Security Administration listed below, are available to me through the above referenced site:

- NC DHHS Social Security Administration Information Exchange Agreements  
Federally Funded Programs  
State Funded Programs
- SOLQ AMENDMENT

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**Group Training**

Signature(s) of the following staff attest to their presence during training and their understanding of the penalties for unauthorized disclosures: (Use a supplemental continuation sheet if necessary and attach to this form)

PRINT NAME	AGENCY/SECTION	SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

  

TRAINER NAME/AGENCY	TITLE	DATE
_____	_____	_____

**SECURITY OFFICER CERTIFICATION**

I certify that the individual(s) listed above have received the specified Social Security Administration Security Training on the date(s) indicated.

\_\_\_\_\_  
Printed Name/Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Revised 02/03/14

County DSS Security Officers should retain this form in their agency.  
State Division of Medical Assistance-Please forward copy to Brenda Gooch.