Consent To Release Information

School District Name

—MEDICAID REIMBURSEMENT—

Student Name:	**Student ID:**
Date of Birth:	**School Name:**

Request:

The District seeks your consent to disclose information concerning your child when applying to Medicaid for reimbursement of covered health-related services and/or IEP service costs. This information would include basic personally-identifying data, as well as documentation of your child's disability or reasons for suspecting a disability, and determination of assessments and /or services needed. Under the Family Education Rights and Privacy Act (FERPA), such information can be disclosed only with parental consent. By giving consent, you will help the District provide additional health related services to all students.

Rights:

- The District will not require you to enroll in Medicaid in order for your child to receive special education services or other disability-related accommodations or services.
- The District will not require you to incur out-of-pocket expenses incurred in filing a claim for services. The District may pay the cost that you would otherwise be required to pay.
- The District will not use Medicaid if that use would: (1) Decrease the available lifetime coverage or any other insured benefit; (2)Result in any cost to your family; (3) Increase premiums or lead to the discontinuation of benefits or insurance; or (4) Risk any loss of your child's eligibility for home and community-based waivers, based on aggregate health-related expenditures.
- You are not required to provide your consent, and your refusal to do so will not prevent your child from receiving special education services or other disability-related accommodations or services at the expense of the District. You are entitled to notice of your rights annually for special education.

Withdrawal of Consent:

- The granting of consent is voluntary and may be withdrawn at any time. However, if you revoke your consent, such revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked.)

AUTHORIZATION

I hereby authorize the District to share necessary information from the above-named child's education records to apply for Medicaid reimbursement for any health-related assessments/evaluations for which I have given consent. I understand and agree that the District may access the above-named child's public benefits or insurance to pay for any health-related services provided pursuant to Part 300 or Part 104 of Title 34 of the Code of Federal Regulation and listed in any IEP/IFSP, Health Care Plan, Section 504 Plan, Service Plan, Behavioral Intervention Plan, or similar plan document that I have signed, or for which I have otherwise given express written permission. I understand that this consent will remain in effect permanently, unless I revoke my consent in writing.

□ **Yes** □ **No** I authorize the District to share necessary information to apply for Medicaid reimbursement.

_____ _____

Parent/Guardian Signature **Date** mm/dd/yyyy

Please send completed form to School Medicaid Department