

Consent for Release of Information to Access Medicaid Reimbursement for Health Related Support Services

SCHOOL DISTRICT: _____

Our school district continues to participate in a system whereby the Federal Government's Medicaid program reimburses local school districts for a portion of the costs of health related special education services provided to Medicaid eligible children. Your child continues to receive services at no cost to you under this system. This initiative simply helps us optimize federal funds in support of local education, as well as offset some of the costs of special education paid for by the local taxes. The information you voluntarily allow to be released by completing this consent form will only be used for the purposes identified. Our district has contracted the services of MSB™ to confidentially administrate our Medicaid Program.

Please fill in the information below, sign the form, and return it to the address indicated.

PARENT/GUARDIAN: _____
(Name of parent or person in parental relationship)

STUDENT'S LEGAL NAME: _____
(First) (Middle Initial) (Last)

STUDENT'S DATE OF BIRTH: _____

As parent/guardian of the child named above, I give permission to the school district to disclose personally identifiable information concerning health-related support services in my child's Individualized Education Plan (IEP) to school districts and designees, State and Federal Medicaid administration representatives for the sole purpose of claiming MEDICAID reimbursement for health-related support services in my child's IEP(s). I understand and agree that the School District may access my or my child's Medicaid benefits to pay for health-related support services in my child's IEP(s).

This permission is for any time my child is Medicaid eligible and in the event that my child becomes Medicaid eligible in the future for the purpose of the release of information relative to IEP ordered services. I also understand that if I refuse to consent to the release of this information, my refusal does not relieve the school district of its responsibility to provide IEP ordered services at no cost to me (34 C.F.R. §300.154 (2013)). I also understand that this consent is voluntary and may be revoked at any time, but that such revocation is not retroactive (34 C.F.R. §300.9 (2006)).

Signature: _____
(Parent or person in parental relationship)

Date: _____
(Month/Day/Year)

Please return this form to: _____