Addendum

School-Based Health Services Program
2012- 2013 School Year

April 2013

VERMONT
AGENCY OF EDUCATION

Special Education Finance
(802) 828-5111

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RELEASE OF INFORMATION (ROI)

On February 14, 2013 34 CFR 300.154 was revised. The revision changed the consent requirements for the School-Based Health Services Program. The new consent requirements are as follows and pertain to services billed for any IEP written or amended 5/1/13 or later.

RELEASE OF INFORMATION FORM REQUIREMENTS

- For any IEP written or amended 5/1/13 or later, a Release of Information form (with a footer revision date of May 2013) must be obtained before billing for dates of service covered by the IEP/Revision.
- A letter must be provided to the parent/guardian explaining the Release of Information form. This letter must include the language provided in the sample letter (attached).
- Please refer to the School-Based Health Services Manual for information regarding joint custody, 18 year old students, emancipated minors, court appointment legal guardians etc…

CONSENT STATEMENT ON THE IEP

- The consent statement on the IEP will be revised to comply with the new federal requirements when the IEP forms are revised for next school year.
- The wording on the IEP has been revised to serve as annual written notification.
- Once IEP's have been updated with the following wording there will not be a need to obtain an "I give permission" indication on the IEP.

For parents/legal guardians who have signed a Release of Information form, the school district is authorized to bill Medicaid for the services listed in the Individual Education Plan (IEP) and to release necessary special education records to a physician/nurse practitioner in order for him/her to reach determination that the services are medically necessary and to individuals within the Agency of Education and the Agency of Human Services charged with processing Medicaid bills for IEP services that are also considered medical services under Vermont Medicaid rules. This consent will remain in effect until I revoke my consent or until the student reaches the age of 18 (after which the student must consent) or the student graduates. Refusal to consent does not affect the school district's responsibility to provide these services to my child at no cost to me. I understand that I may revoke this consent at any time; if I revoke this consent, it will apply to billing for services from that date forward.

SAMPLE LEGAL GUARDIAN LETTER

(Use Your School District Letterhead)

(insert date)

(insert legal guardian's name)
(insert legal guardian's address)

Dear (insert legal guardian's name):

The Vermont Medicaid program (also known as Green Mountain Cares) will reimburse school districts for services provided to students on an Individualized Education Program (IEP) and enrolled in one of Vermont's Medicaid programs. With your consent we can bill the Medicaid program for some services included in your child's IEP. Please complete the attached Release of Information form. Consent to the release of information is voluntary.

Allowing the school district to bill Medicaid for services outlined in your child's IEP will in no way affect your child's Medicaid benefits. The school district will only release the records essential for billing purposes. If you choose not to give your consent, your child will continue to receive the same level of services required in the IEP. If you have other health insurance, as well as Medicaid, your other health insurance will not be billed for services provided by the school. The consent will remain in effect until it is revoked.

The funds the school receives from billing Medicaid will be used to provide additional programs for all students.

If you have any questions about this program, please call me (insert your name), at (insert phone number).

Thank you for your response.

Sincerely,

(insert name and title)

SAMPLE LEGAL GUARDIAN LETTER

(Use Your School District Letterhead)

(insert date)

(insert legal guardian's name)
(insert legal guardian's address)

Dear (insert legal guardian's name):

The Vermont Medicaid program (also known as Green Mountain Cares) will reimburse school districts for services provided to students on an Individualized Education Program (IEP) and enrolled in one of Vermont's Medicaid programs. With your consent we can bill the Medicaid program for some services included in your child's IEP. Please complete the attached Release of Information form. Consent to the release of information is voluntary.

Allowing the school district to bill Medicaid for services outlined in your child's IEP will in no way affect your child's Medicaid benefits. The school district will only release the records essential for billing purposes. If you choose not to give your consent, your child will continue to receive the same level of services required in the IEP. If you have other health insurance, as well as Medicaid, your other health insurance will not be billed for services provided by the school. The consent will remain in effect until it is revoked.

A physician's review is required before services can be billed to Medicaid. The (insert school name) utilizes the services of a contracted physician to review information for Medicaid billing purposes. If you would prefer that only your child's physician review his/her records, please place a note on the Release of Information form.

The funds the school receives from billing Medicaid will be used to provide additional programs for all students.

If you have any questions about this program, please call me (insert your name), at (insert phone number).

Thank you for your response.

Sincerely,

(insert name and title)

Release of Special Education Information for
Medicaid Billing Purposes

Student's Name:	
Student's Date of Birth:	
Student's Medicaid ID#:	
Parent/Guardian:	

By signing this form I give consent to my child's school district for the release of special education evaluations, IEPs, and Medicaid claims documents to:

- A physician or nurse practitioner in order for him/her to reach a determination that the services are medically necessary; and
- Individuals within the Agency of Education and the Agency of Human Services (AHS) charged with processing Medicaid bills for medical services included in my child's IEP.

The school district will only release the records essential for billing purposes and the above individuals will only review the documents necessary to perform their assigned tasks in the Medicaid billing process.

Consent to the release of information is voluntary. I understand that if I give consent to the release of such information this consent will remain in effect until it is revoked or the student reaches the age of 18 (after which the student must consent) or the student graduates. I understand that if I refuse to give consent, my refusal will only affect the billing for IEP medical services to Medicaid; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to release information for Medicaid billing at any time; if I revoke this consent, it will apply to billing for services from that date forward.

Signature of Parent/Legal Guardian:_____Date:_____

*NOTE--If the child is in joint custody at the time the form is requested, each legal guardian needs to sign a form before billing can occur.

Release of Special Education Information for
Medicaid Billing Purposes—18 Year Old Student

Name:	
Date of Birth:	
Medicaid ID#:	

By signing this form I give consent to my school district for the release of special education evaluations, IEPs, and Medicaid claims documents to:

- A physician or nurse practitioner in order for him/her to reach a determination that the services are medically necessary; and
- Individuals within the Agency of Education and the Agency of Human Services (AHS) charged with processing Medicaid bills for medical services included in my IEP.

The school district will only release the records essential for billing purposes and the above individuals will only review the documents necessary to perform their assigned tasks in the Medicaid billing process.

Consent to the release of information is voluntary. I understand that if I give consent to the release of such information this consent will remain in effect until it is revoked or I graduate. I understand that if I refuse to give consent, my refusal will only affect the billing for IEP medical services to Medicaid; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to release information for Medicaid billing at any time; if I revoke this consent, it will apply to billing for services from that date forward.

Signature:_____Date:_____