PARENTAL CONSENT FOR RELEASE OF EDUCATIONAL INFORMATION FOR MEDICAID FUNDING

TERMS, RIGHTS AND RESPONSIBILITIES

By signing this application, I understand and confirm that:

- I have been fully informed in my native language or other mode of communication that the granting of my consent to share information for the purpose of obtaining Medicaid reimbursement for the services provided per my child's individualized education program (IEP) is voluntary and may be revoked at any time and that if I revoke my consent, it does not negate (undo) an action that occurred after my consent was given and before my consent was revoked.
- If I refuse consent to allow use of Medicaid insurance to pay for special education services, the school district must still provide all required special education services at no cost to me.
- The use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program.
- I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I, _____, as parent/guardian of _____
(Name of parent or person in parental relationship) **(Name of child)**

give permission to the public agency (school district, municipality or Medicaid provider) to use Medicaid to pay for IEP services and to such public agency and to each approved private special education school or provider who provides IEP services to my child to disclose information regarding diagnosis and procedure codes for billing Medicaid for services described in my child's IEP and for evaluations in relation to the services; and in the event of an audit, documentation required to support services reimbursed by Medicaid from my child's educational records to local, State and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for covered health-related support services for each service and for each school year in which service is provided as recommended in my child's IEP if my child is or becomes Medicaid-eligible.

I understand and agree that the School District may access my child's or my public benefits or insurance to pay for services under Part 300 of the Individuals with Disabilities Education Act (IDEA).

I also consent to communications with and requesting prescriptions or physician's order from my child's medical provider for OT, PT, speech language services, psychological counseling services, skilled nursing services and evaluations services as stated on the IEP. ***(Please provide the name and phone number of your child's current physician at the bottom of this sheet.)***

I give my consent voluntarily and understand that I may withdraw that consent at any time. I also understand that my child's entitlement to a free appropriate public education (FAPE) is in no way dependent on my granting consent.

Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____