Parental Notice for Release of Info/One-Time Consent to Bill Medicaid

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

School/District Contact: _____ **Title:** _____ **Phone:** _____

Dear _____:

The purpose of this letter is to ask for your permission (also known as consent) to share records and information about your child with Medicaid. The school district needs to share information with Medicaid pertaining to your child, including name, date of birth, gender, and type of services provided.

With your permission, the school district will be able to seek partial reimbursement for services provided by Medicaid. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

Under Federal law, the school district cannot share with Medicaid information about your child without your permission. (34 C.F.R. 99.30(b); 34 CFR 300.154(d)(2)(iv)(A)-(B)). As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for Medicaid for your child to receive the health-related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge Medicaid for services provide. The school district can agree to pay the co-pay or deductible if any such cost is expected.
3. If you give the school district permission to share information with and request reimbursement from Medicaid:
    a. **This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family's use of Medicaid benefits outside of the school.**
    b. **Your permission will not affect your child's special education services or IEP/IFSP rights in any way, if your child is eligible to receive them.**
    c. **Your permission will not lead to any changes in your child's Medicaid rights; and**
    d. **Your permission will not lead to any risk of losing eligibility for other Medicaid or Medicare funded programs.**
4. If you give permission, you have the right to change your mind and withdraw your permission at any time.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with Medicaid for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

☐ **I AGREE** and give permission to the School to share with Medicaid records and information concerning my child and their health-related services, as necessary. I have read the notice and understand it. Any questions I had were answered.

☐ **I DO NOT** give permission for the School to release information for Medicaid billing purposes and **I DO NOT** give consent for the School to access/bill Medicaid insurance for provided services.

*I have the authority to enter into this agreement and acknowledge that my electronic signature below is legally binding. I agree that electronic versions of this document shall be given the same weight and deference as a hard copy.

_____ _____

Parent/Guardian Signature Date