Dear Parent/ Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

This is to ask your permission (consent) to bill your child’s Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) or individual family service plan (IFSP). This consent allows the school district/municipality to bill for covered health-related services and to release information to the Medicaid Billing Agent for that purpose.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Print child’s name)

have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services. (for children ages 3-21).

I understand and agree that the school district or municipality may access Medicaid to pay for special education and related services provided to my child.

I understand that:

* Providing consent will not impact my child’s/my Medicaid coverage;
* Upon request, I may review copies of records disclosed pursuant to this authorization;
* Services listed in my child’s IEP/IFSP must be provided at no cost to me whether or not I give consent to bill Medicaid;
* I have the right to withdraw consent at any time; and
* The school district must give me annual written notification of my rights regarding this consent for my child age 3 and older.

I also give my consent for the school district/municipality/service provider to release the following records/information about my child to the State’s Medicaid Agency for the purpose of billing for special education and related services that are in my child’s IEP/IFSP. The following records will be shared.

|  |  |
| --- | --- |
| **Records to be shared (such as records or information about services your child receives)** | |
| Prescription | Service Provider Attendance |
| Referral | “Under the Direction of” Certification |
| Treatment Logs | “Under the Supervision of” Certification |
| Individualized Education Program IEP or  Individual Family Service Plan IFSP | “Under the Direction of” Logs |
| Attendance Records | “Under the Supervision of” Logs |
| Bus Logs | Calendar |
| Other unnamed documents needed to  support a claim to Medicaid |  |

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child’s right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child’s IEP/IFSP will be provided to my child at no cost to me.

Parent/Guardian Name and Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_