Document Date:

Consent to Bill School-Based Medicaid

Student Name: District ID: State ID: Grade: Sex:

Native Lang: Ethnicity: Birthdate: Age:

District: School: Phone:

THE MEDICAID SCHOOL-BASED SERVICES PROGRAM IN IDAHO:

- Provides partial reimbursement to school districts for health-related special education and related services such as evaluations, assessments, speech therapy, physical therapy, occupational therapy, nursing, personal care, orientation and mobility, specialized medical transportation, and assistive technology services.
- Does NOT affect a family's or child's Medicaid insurance benefits and there is NO cost to the family, now or in the future.
- Helps Idaho school districts offset some of the costs of health care provided to children.
- Is voluntary and requires a parent/guardian to provide written consent to release information about their child to a Medicaid billing agent to obtain reimbursement. This may include current or past assessments and evaluations, current or past IEPs, dates of school attendance, and progress notes from individuals providing the school-based services.

☐ **I DO NOT** give consent for the School District to bill Medicaid for covered services in my child's education program.

☐ **I DO** give consent for the School District to bill Medicaid for covered services in my child's education program. I authorize the School District to release information to the Medicaid billing agent for eligibility verification, billing and auditing regarding any health-related school-based services provided to my child.

Student's Name as it Appears on Medicaid card:

Student Medicaid ID:

I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING FEDERAL PROVISIONS:

34 CFR 300.154(d)(2)(iv)

- I have received written notification from the School District that explains my federal rights regarding the use of public benefits or insurance to pay for school-based services provided to my child that are identified on my child's IEP or IFSP.
- I only need to give permission one time, and I will be informed annually of my rights.
- I may request a copy of my child's records that are shared with the Medicaid billing agent.
- I may withdraw my permission in writing at any time by notifying
- If I withdraw my permission it will apply to any billing for school-based services from that date forward and all services identified on my child's IEP or IFSP will still be provided at no cost to me.

I UNDERSTAND THAT BEFORE THE SCHOOL DISTRICT MAY BILL MEDICAID FOR SCHOOL-BASED SERVICES RECEIVED BY MY CHILD, IDAHO STATE REGULATIONS REQUIRE THE SCHOOL DISTRICT TO:

IDAPA 16.03.09.854.8

- Request the name of my child's primary care physician from me; and
- Request written consent from me to release and obtain information between my child's primary care physician and the School District.

☐ I **DO** give written consent for the School District to release and obtain information with my child's primary care physician whose name is:

☐ I **DECLINE** to provide the name of my child's primary care physician and I DO NOT give written consent for the School District to release and obtain information with my child's primary care physician. I understand my refusal to give consent does not prevent the School District from billing Medicaid.

_____ _____

Parent/Guardian Signature Date