

(District Letterhead)

**PARENTAL CONSENT FOR BILLING PUBLIC INSURANCE (Medicaid)**

Consent to Release Information: I consent to allow \_\_\_\_\_ (LEA) to bill Medicaid for eligible I.E.P. services. I also consent for the local education agency to release information about my child's participation in services billed to Medicaid to participating physicians, other health care providers, the Department of Healthcare and Family Services, and any LEA billing agent as necessary to process Medicaid claims for reimbursement for Medicaid covered health-related services and the evaluations for services outlined in the IEP.

Procedural Safeguard: I understand my right to deny consent for the school system to access my child's Medicaid coverage to seek reimbursement for the health-related services. I understand that allowing the school system to make these claims will not affect the delivery of these services to my child. I understand that services provided by the LEA's special education program will not count against limits for Medicaid programs. I understand that my permission is voluntary and may be revoked by contacting the district in writing at anytime. I also understand that I have the right to request a copy of the records disclosed.

**(Check only one box below)**

- I give permission to release information needed in order to bill Medicaid for services provided pursuant to my child's IEP. The information which may be released by the LEA may include:
- My child's name and social security number
  - My child's date of birth
  - My child's referral and evaluation information and reports
  - The dates and times service is provided to my child at school
  - The IEP goals my child is working on with these services
  - The progress my child is making, including progress notes and report cards

The specific services included in my release are:

- Audiology services: \_\_\_\_\_ services per week or month (circle one)  
Behavioral services: \_\_\_\_\_ services per week or month (circle one)  
Nursing services: \_\_\_\_\_ services per week or month (circle one)  
Occupational Therapy: \_\_\_\_\_ services per week or month (circle one)  
Physical Therapy: \_\_\_\_\_ services per week or month (circle one)  
Psychology services: \_\_\_\_\_ services per week or month (circle one)  
Speech Therapy: \_\_\_\_\_ services per week or month (circle one)  
Social work services: \_\_\_\_\_ services per week or month (circle one)

- I do not give my permission for this information to be released.

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_