



Student name: _____ DOB: _____ School: _____ GR: _____
IDEA Notification: reviewed with parent/guardian? Y or N Date: _____
FERPA Consent: previous form on file? Y or N (If no, please complete consent form below.)

IDEA Annual NOTIFICATION Parental Rights regarding Use of Public Benefits or Insurance

This **notification**, provided **annually** to you, outlines your rights and protections under Part B of the Individuals with Disabilities Act (IDEA), so that you can make an informed decision about whether to give your written consent to St. Johns County School District to disclose your child's identifiable information to Medicaid for the purpose of receiving Medicaid reimbursement for Exceptional Student Education services provided to your child while at school. This notification advises you of the following:

- St. Johns County School District is required to provide the special education and related services included in your child's IEP **at no cost** to you or your child.
- Medicaid Certified School Match is a federal program which reimburses school districts a portion of the costs associated for related services in the areas of occupational and physical therapy; speech/language therapy; nursing; behavioral health and specialized transportation. This federal reimbursement program **does not affect** your Medicaid benefits or any other services received from an outside provider.
- If you choose not to provide your consent for Medicaid reimbursement purposes, your child will continue to receive all required special education and related services under IDEA **at no cost** to you or your child.
- You may withdraw your consent at any time by providing written notice to the school district.
- Copies of records disclosed as a result of authorization to bill are available upon request.

Family Educational Rights and Privacy Act (FERPA) CONSENT to Disclose Identifiable Information for Medicaid Purposes

_____ **YES**, I authorize the school district of St. Johns County, Florida, to release and exchange my child's confidential information to agencies of the State of Florida which would allow St. Johns County Schools to **verify** Medicaid eligibility; **bill** Medicaid for reimbursable Certified School Match services referenced on my child's Individual Education Plan (IEP), and **receive** Medicaid reimbursement for Exceptional Student Education (ESE) services provided to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent.

_____ **NO**, I do not give my consent to disclose my child's identifiable information for Medicaid purposes.

Signature of Parent / Guardian

Date

Your consent to disclose identifiable information for Medicaid purposes is a **one-time requirement** and will remain in effect for the period of time your child is enrolled in Exceptional Student Education programs.

If you have any questions about this information, please contact Exceptional Student Education, 904-547-7672 or Toni Dendler, Medicaid Specialist, 904-547-7686.

Effective: 8/2013

IDEA Notice: Review with parent at annual IEP meeting. Retain original in file.

FERPA Consent: One-time requirement. Retain original in file; forward copy of refusal (only) to Medicaid Specialist.

Version 8/2014