Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

_____ School District

The Individuals with Disabilities Education Act 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school [34 CFR Section 300.154(d)(2)(iv)(A)-(B)]. Our school district wishes to seek reimbursement for certain services provided to your child by accessing Medicaid. IDEA requires that we obtain your written informed consent for the purpose of releasing certain information related to seeking Medicaid reimbursement. Medicaid reimbursement helps the school district fund costs of providing special education and related services.

Consent given or denied: (please read, initial, sign and date at the bottom)

___ **I understand and give my consent** to the district to share information about my child with the state Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the district's Medicaid billing agent or billing facilitator for the district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary to receive an appropriate education at no charge to my child in accordance with 34 CFR section 300.154(d)(2)(v)(D). If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

The information shared may include my child's name, date of birth, address, primary special education disability, Social Security number, Florida Medicaid identification number, and the type and amount of health services provided, including the times and dates services were provided. Services may include assistive communication services, physical therapy services, speech therapy services, hearing and language therapy services, occupational therapy services, behavioral services, transportation services, nursing services.

The records to be released or exchanged may include IEPs, assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes, and nursing reports or records.

___ **I do not give my consent** to the district to share information about my child in order for the district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.

Parent/Guardian Signature: _____ Date signed: ____/____/_____

Parent/Guardian's Name (printed): _____

Student/Child's Full Name (printed): _____

Student/Child's Date of Birth: _____/_____/_____