2012-2013 School District Medicaid Consent Form for IEPs and IFSPs

School District:_____School:_____

The Department of Health and Human Services sponsors a program allowing our school district to seek reimbursement for health-related services we provide to children with Medicaid health insurance. This program helps us maximize federal funds for support of additional health services in our schools. *Your child will continue to receive services at no cost to you under this program*. Granting the district permission to receive these federal funds *in no way limits any other MEDICAID benefits* your child can receive outside of school. By giving your consent, you help our school district expand health and health-related services for all children. This consent will be considered valid for the entirety of the current school year or until the anniversary date of the IEP. The students truly benefit from the success of this program.

My child may receive any of the following services according to his/her IEP:
assessments and evaluations - nursing services - speech therapy
occupational and physical therapy - psychological therapy - orientation/mobility
social work and counseling services - audiology - one on one health aide services
medication administration - transportation - targeted case management services
personal care services - other _____

CHILD'S NAME _____
(First Name-Middle Initial-Last Name-PLEASE PRINT.)

CHILD'S DATE OF BIRTH ____/____/____
month/day/year

CHILD'S SOCIAL SECURITY NUMBER __ __ __-__ __-__ __ __ __ (optional)

CHILD'S MEDICAID NUMBER __ __ __ __ __ __ __ __ __ (If currently eligible.)

CHILD IS NOT CURRENTLY ELIGIBLE _____ (Please check here if child is not currently eligible.)

As parent/guardian of the child named above, I give the school district permission to release information related to health services he/she has received at school to state and/or federal Medicaid representatives for the sole purpose of allowing the school district to seek reimbursement from Medicaid for those health services.

Signature:_____ Date:_____

PARENT/GUARDIAN _____
(PLEASE PRINT Name of parent or person in parental relationship)