Medicaid Parent Notification and Consent

PARENT NOTIFICATION AND CONSENT

For billing the State for Medicaid School-Based Services

Student Name: **Birth Date:**

Attending ISD:

NOTIFICATION

If any of the services listed below are included on your child's IEP (Individualized Education Program), and if your child was eligible for Medicaid at any time during the school year, we request your permission to bill the state Medicaid program to receive funding to help support the services your child received. Supported services include:

Speech/ Language Therapy, Occupational Therapy, Physical Therapy, Social Work Services, Psychological Services, Nursing Services, Orientation and Mobility, Assistive Technology Services, Case Management, Personal Care, Evaluations and Transportation.

Billing the state Medicaid program for your child's School-Based Services does NOT affect your family's Medicaid insurance benefits, and is at NO cost to your family, now or in the future.

We are simply asking your permission to claim funds reserved by the state to help schools provide the services listed on your child's Special Education plan.

Billing the state's Medicaid program requires that we release information to the state about your child. The information released could include date of birth, disability, gender, school, date of therapy, type of therapy, and progress reports. You will receive annual notification about information released in the Parent Handbook with Procedural Safeguards. Schools have released this information to the state program since 1993, but now need your permission because of changes in federal law.

You have the right to refuse consent to bill the state Medicaid system, and you have the right to revoke this consent at any time. If you check No below, the district will still provide the services but the district will not receive funding from the state Medicaid system for these services.

CONSENT

☐ **Yes, I understand, agree, and consent that the ISD and its local school districts may:**

a. **release Personally Identifiable Information (PII) about my child (including date of birth, disability, gender, school, date of therapy, type of therapy, progress reports to Michigan Medicaid and its billing agencies for Medicaid reimbursement of School-Based Services; and**
b. **bill my child's Medicaid insurance for reimbursement of School-Based Services as described in my child's plan.**

I understand I may revoke this consent in writing at any time.

☐ **No, I do not give permission for the ISD and its local school districts to bill the state Medicaid system for reimbursement of School-Based Services provided to my child.**

Parent/Guardian/Student Signature:_____ **Date:**_____