Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

Suwannee County School District

The Individuals with Disabilities Education Act 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school. Our 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 review requests related to services provided to my child. I understand that if I refuse to give consent, my refusal does not relieve the school district of its responsibility to provide required IEP and other services at no cost to me. I understand that I may revoke this consent to release information for Medicaid billing at any time; if I revoke this consent, it will apply to billing services from that date forward.

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 the 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/exchanged may include individual education plans (IEPs), assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes and nursing reports/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: ___/___/___