Stonington Public Schools
Written Consent and Parent Permission
for Connecticut School-Based Child Health Program

Student Name: _____ Date of Birth: _____

Stonington Public Schools participates in the Connecticut Medicaid School-Based Child Health Program (SBCH). The SBCH program allows school districts to receive state and federal funding for services that are provided to eligible students who receive special education related health services listed in their IEP or 504 plan and qualify for Medicaid (HUSKY) benefits.

This one-time consent form allows the school district to seek reimbursement from the state for eligible students who have a covered health-related service as part of the student's IEP or 504 plan.

- Examples of these services are: Occupational Therapy, Physical Therapy, Speech-Language, Hearing services, Psychological Services, Social Work, Nursing, and Individual Assessments/Evaluations as recommended by the Planning and Placement Team.

- If your child receives any of the above services and qualifies for Medicaid (HUSKY) benefits at any time during the school year, **we request your permission to release information to access school-based Medicaid(HUSKY) reimbursement for the school district.**

- Information to the Medicaid agency may include student's name, date of birth, Medicaid ID and dates and services provided.

- Any reimbursement received from the Medicaid program does not affect or impact other benefits to which my child is entitled, including any eligible services outside of school, other state programs and/or Medicaid waivers. **There is NO cost to the family, now or in the future**.

- The school district will provide all services to my child whether or not I grant my written consent. My consent is voluntary and I have the right to withdraw this consent at any time.

☐ I GIVE MY CONSENT to allow the school district to access my child's public benefits or insurance information (ex: Medicaid/HUSKY) in order to seek reimbursement for services rendered as listed on the Individualized Education Program (IEP).

☐ I DO NOT give my permission to allow the school district to access and seek reimbursement for SBCH eligible services prescribed in my student's IEP/504 plan.

Signature of Parent/Guardian Date

Please return this form to your child's case manager or to: **Stonington Public Schools, 204 Mistuxet Ave, Mystic, CT 06355**. Forms may also be faxed: **(203) 291-2524** or scanned/emailed to Rachael Dessaules @ rachael.dessaules@stoningtonschoools.org