

Kentucky Parental Notice for One Time Consent to Allow the School District to Access Kentucky Medicaid Benefits

School District Name: _____

School/District Contact: _____

Dear Parent/Guardian _____

The purpose of this letter is to ask for your permission to release information needed to recover costs from Medicaid for eligible school-based services. Local education agencies in Kentucky have been approved to receive partial reimbursement from Kentucky's Department for Medicaid Services (DMS) for the costs of certain health-related services provided by the district to your child (or children).

With your permission, the school district will be able to seek partial reimbursement for medically necessary services to Medicaid recipients in accordance with an Individualized Education Program (IEP), an Individual Family Service Plan (IFSP), or are otherwise medically necessary.

The school district will need to share following types of information about your child: name, date of birth; gender; social security number, Individual Education Plan, Service records and any relevant information. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share information about your child without your permission. When you give permission, please be advised of the following:

1. This will allow the release of information, for the sole purpose of billing Medicaid services or auditing, to the following agencies: DMS, Kentucky Department of Education (KDE), Kentucky Department for Public Health, Centers for Medicare and Medicaid Services (CMS), any agency commissioned to audit this program and contractual third-party billing agents.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services.
3. This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family's use of benefits outside of school. This will not affect your child's special education services or IEP rights.; and it will not lead to any risk of losing eligibility for other Medicaid or DMS funded programs.
4. You have the right to change your mind and withdraw your permission at any time.

I give permission to the school district to share with DMS information concerning my child(ren) and their health-related services, as necessary. I understand that this will help our school seek partial reimbursement of DMS covered services.

Parent/Guardian Signature: _____ Date: _____

Child's Name:	Date of Birth:	Medicaid Number:
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