Savannah-Chatham County Public School System
208 Bull Street / Savannah, Georgia 31401 / 912.395.1016

Parental/Guardian Medicaid or PeachCare for Kids Consent Form

Student Name: _____

Medicaid Number: _____ Date of Birth: _____

Dr Name (**student's physician):** _____
Dr Phone Number: _____
Dr Address/Practice Name: _____

Savannah Chatham County Public School System is providing health-related services that are medically necessary for your child. These services are identified in his/her Individualized Education Program (IEP), the Letter of Medical Necessity (LMN), or the Plan of Care (POC) that your child's doctor signed. The Medicaid or PeachCare for Kids program is required to cover the cost of certain services.

Savannah Chatham County Public School System cannot bill Medicaid or PeachCare for Kids without your consent. If you will allow Savannah Chatham County Public School System to bill Medicaid or PeachCare for Kids for these medically necessary services, **please check the "YES" Box and sign below**.

☐ **YES** I authorize Savannah Chatham County School System to bill Medicaid or PeachCare for Kids for the health-related services listed in my child's IEP, the Plan of Care, or the Letter of Medical Necessity.

☐ **NO** I do not want Medicaid or PeachCare for Kids billed for the health-related services my child is receiving.

My child receives therapy from a private provider (outside of the school system): ☐ YES ☐ NO
If YES, please circle each that apply: Occupational Therapy, Physical Therapy, and/or Speech-Language Therapy

If YES, please provide the **name** and **number** of the private therapy provider:

_____

If YES, please indicate which days your child receives private therapy: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri

PLEASE CONTACT RISK MANAGEMENT IF YOUR CHILD'S PHYSICAN CHANGES

To comply with the requirements of the Family Educational Rights and Privacy Act (20 U.S.C.§1232g and 34 CFR §99.30 and §300.622), I further consent to the release of my child's education records that contain information about the health-related services provided at school and billed to the Georgia Department of Community Health (DCH). I understand these records may be used, as necessary, to make sure the health services received at school are not an exact copy of health services provided by other healthcare providers. I also understand these records will allow DCH (or its agents) to perform reviews of the Medicaid payments made to the school. I understand that I may request a copy of the records disclosed pursuant to this consent.

Parent/Guardian Name (Please print): _____

Parent Signature: _____ Date: _____

It is my responsibility as a parent to notify the SCCPSS Special Education Department in writing if I ever decide to withdraw this consent allowing SCCPSS to seek reimbursement from Medicaid or PeachCare for Kids. I understand this consent is for the school lifetime of my child.

If you have any questions, please call: Savannah Chatham County Public School System **912-395-1016**