Notification of Use of Public Benefits (Medicaid) or Private Insurance to Pay for Services Under the IDEA

Last Name: _____	First Name: _____	Student ID#: _____
Date Created: _____	Grade: ____	School: _____

This notification is to inform you of the intent of the School District and the South Carolina Department of Education (SCDE) to bill Medicaid and/or third-party insurance and receive payment from Medicaid and/or any third-party insurer for services, as permitted under the Individuals with Disabilities Education Act (IDEA), and as set forth in your child's individualized education program (IEP). The District and the SCDE may bill Medicaid or a third-party insurer for diagnostic and psychological evaluation services, behavioral health services, nursing services, and other health-related screenings and treatment services billable to Medicaid or a third-party insurer with or without the requirement of an IEP. The District must provide this notice to you prior to requesting your consent to bill Medicaid and/or any third-party insurer once a year for services that the District will provide in the future.

This document also serves as notice that the District and the SCDE will release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to the South Carolina Department of Health and Human Services and any applicable third-party insurer regarding services provided to your child.

Medicaid and third-party insurance reimbursement for billable services provided by the District will not affect any other Medicaid services or insurance benefits for which your child is eligible. The District cannot bill Medicaid or your child's insurance program if it will decrease available lifetime coverage or any other insurance benefit, result in the family paying for services that would otherwise be covered, increase your insurance premiums, or risk loss of eligibility for waivered programs. You are not responsible for paying any outstanding deductibles, co-payments, or co-insurance related to the District billing Medicaid or your child's insurance program for services provided by the District. Your child will receive the services listed in the IEP regardless of whether your child is covered by public or private insurance programs and regardless of whether you provide consent to access those benefits. Your refusal to provide consent to release personally-identifiable information to Medicaid or any third-party insurer does not relieve the District of its responsibility to ensure that all required services are provided at no cost to you.

Any previous, current, or future consent to bill Medicaid or third-party insurance is voluntary and you may revoke your consent at any time. If you choose to revoke consent, that revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked).

The District and the SCDE will continue to operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding your child's treatment and provision of services.

Student's Name: _____ **Medicaid #**: _____

Florence School District One

Consent to Bill Private Insurance and Medicaid

Last Name: _____	First Name: _____	Student ID#: _____
Date of Birth: _____	Grade: _____	School: _____

The South Carolina School District and the South Carolina Department of Education (SCDE) have my permission to provide services to my child and release and exchange medical, psychological, and other personally identifiable confidential information, as necessary, to the South Carolina Department of Health and Human Services (SCDHHS) and any applicable third-party insurer regarding billable services provided to my child. I understand the purpose of this consent is to bill Medicaid and/or private third-party insurer for services under the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the SCDE my permission to bill and receive payment from Medicaid and any third-party insurer for diagnostic and psychological evaluation services, behavioral health services, nursing services, and other health-related screenings and treatment services billable to Medicaid or a third-party insurer with or without the requirement of an individualized education program (IEP). The District provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to my signing this consent to release information to bill Medicaid or any third-party insurer and prior to accessing Medicaid or my child's third-party insurance benefits.

I further understand that the District must provide me annual written notification of my rights relative to Medicaid or any third-party insurer accessing my child's information and before the District and the SCDE access my benefits to pay for services under the IDEA. This consent for release of information to bill Medicaid and any third-party insurer is a one-time consent and is not required annually thereafter, unless there is a change in the type or amount of services to be provided to my child or a change in the cost of the services to be charged to Medicaid or a third-party insurer.

I understand that Medicaid and third-party insurance reimbursement for billable services provided by the District and the SCDE will not affect any other Medicaid services or insurance benefits for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether my child is covered by public or private insurance programs and regardless of whether I provide consent to access those benefits. I understand that my refusal to consent to the SCDHHS or any third-party insurer accessing my child's personally identifiable information does not relieve the District of its responsibility to ensure that all required services in my child's IEP are provided at no cost to me.

I understand that this consent is voluntary on my part and may be revoked at any time. If I later revoke consent, the revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked).

I also understand that the District and the SCDE will operate under the guidelines of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of services.

Student's Name: _____ DOB: _____ Medicaid Number: _____

_____ _____

Parent/Guardian Signature Date