Student Name:_____
School:_____
Student Local ID: _____ **Date of Birth:** _____ **Grade Level:** _____

Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

The Individuals with Disabilities Act 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school. Medicaid reimbursement helps the school district fund costs of providing special education and related services to students in Exceptional Student Education programs.

Our school 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.

The information shared 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, may include your child's name, date of birth, address, primary exceptional education disability, Social Security number, Florida Medicaid identification number, and the type and amount of services provided, including the times and dates services were provided.

The type of records to be released or exchanged may include IEPs, assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes, and nursing reports or records.

Consent given or denied: (*please read, check one box, sign and date at the bottom and return to your child's school)*

◯ **YES, I understand and give my consent** to the district to release and exchange my child's personally identifiable information to agencies of the State of Florida which would allow the school district to **verify** Medicaid eligibility, **bill** Medicaid for reimbursable services referenced on my child's IEP, **receive** Medicaid reimbursement for services provided to my child while at school, and **satisfy audit and review requests** related to services provided to my child at school.

I understand that I may withdraw my consent to release information for Medicaid reimbursement at any time by providing written notification to the school district. I understand that my child will continue to receive services referenced on his or her IEP whether or not I give consent or withdraw consent at a later time. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

I understand that my consent to release personally identifiable information for Medicaid purposes is a **one-time requirement** and will remain in effect for the period of time my child is enrolled in Exceptional Student Education programs, unless I withdraw this consent.

◯ **NO, I do not give my consent** to disclose my child's personally identifiable information for Medicaid purposes.

Parent/Guardian Signature: _____ **Date signed:** _____

Parent/Guardian's Name (printed): _____

Student/Child's Full Name (printed): _____

Student/Child's Date of Birth: _____

DRAFT