HILLSBORO SCHOOL DISTRICT

**Parent Consent to**
**Access Public Insurance (Medicaid) and**
**Release Personally Identifiable Information for Medicaid Billing Purposes**
**For Ages 3 - 21**

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission, also known as consent, to share information about your child with the Oregon Health Authority (OHA), Oregon's State Medicaid Agency, in order to access Medicaid reimbursement for covered health services provided in the school setting. School districts and Early Childhood Special Education (ECSE) programs may receive partial reimbursement from the OHA for the costs of Medicaid covered health services provided to Medicaid-enrolled children with disabilities. In order to access Medicaid reimbursement, your child's school district or ECSE program needs your consent to share information about your child with the OHA. The following type of information about your child may need to be shared with the OHA: name; date of birth; type of services provided, the date(s) services are provided, and by whom; attendance records, and State Student Identification Number (SSID).

**Parental Notification**

School districts and ECSE programs cannot share information about your child without your permission. As you consider giving your permission, please know that you have the following rights:

1. The school district cannot require you to sign up for the Oregon Health Plan (Medicaid) in order for your child to receive the school health services to which your child is entitled.
2. The school district cannot ask you to pay anything for your child's health-related services provided in the school setting. This means that they cannot ask you for a co-pay or deductible in order to bill the OHA for the services provided.
3. If you give the school district permission to share information with the OHA in order to bill Medicaid:
    a. 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 Medicaid benefits outside of school.
    b. Your permission will not affect your child's special education services or Individualized Education Program (IEP) or Section 504 rights in any way, if your child is eligible to receive them.
    c. Your permission will not lead to any changes in your child's Medicaid rights.
    d. Your permission will not lead to any risk of losing eligibility for other Medicaid or OHA funded programs.

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4. If you give permission, you have the right to change your mind and withdraw your permission at any time. You must let the school district know ***in writing*** that your permission is withdrawn.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with the OHA for the purpose of seeking Medicaid reimbursement for the cost of covered school health services, the school district will continue to be responsible for providing your child with the health services, at no cost to you.

**Parental Consent**

I have read the notice and understand it. Any questions I had were answered.

☐ I give permission to the school district or ECSE program to share with the OHA records and information concerning my child and their Medicaid covered health services, as necessary. I understand that this will help the school district or ECSE program seek partial reimbursement for the cost of Medicaid covered services provided to my child.

☐ I do not give permission to access my public insurance (Medicaid) or to disclose, for billing purposes, my child's personally identifiable information listed below.

Date of Initial Written Notification to Parent: _____

| Child's Name | Date of Birth | SSID |
|---|---|---|
| | | |

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

**Please submit this form to medicaidbilling@hsd.k12.or.us**